

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. PAGES 7-12, HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

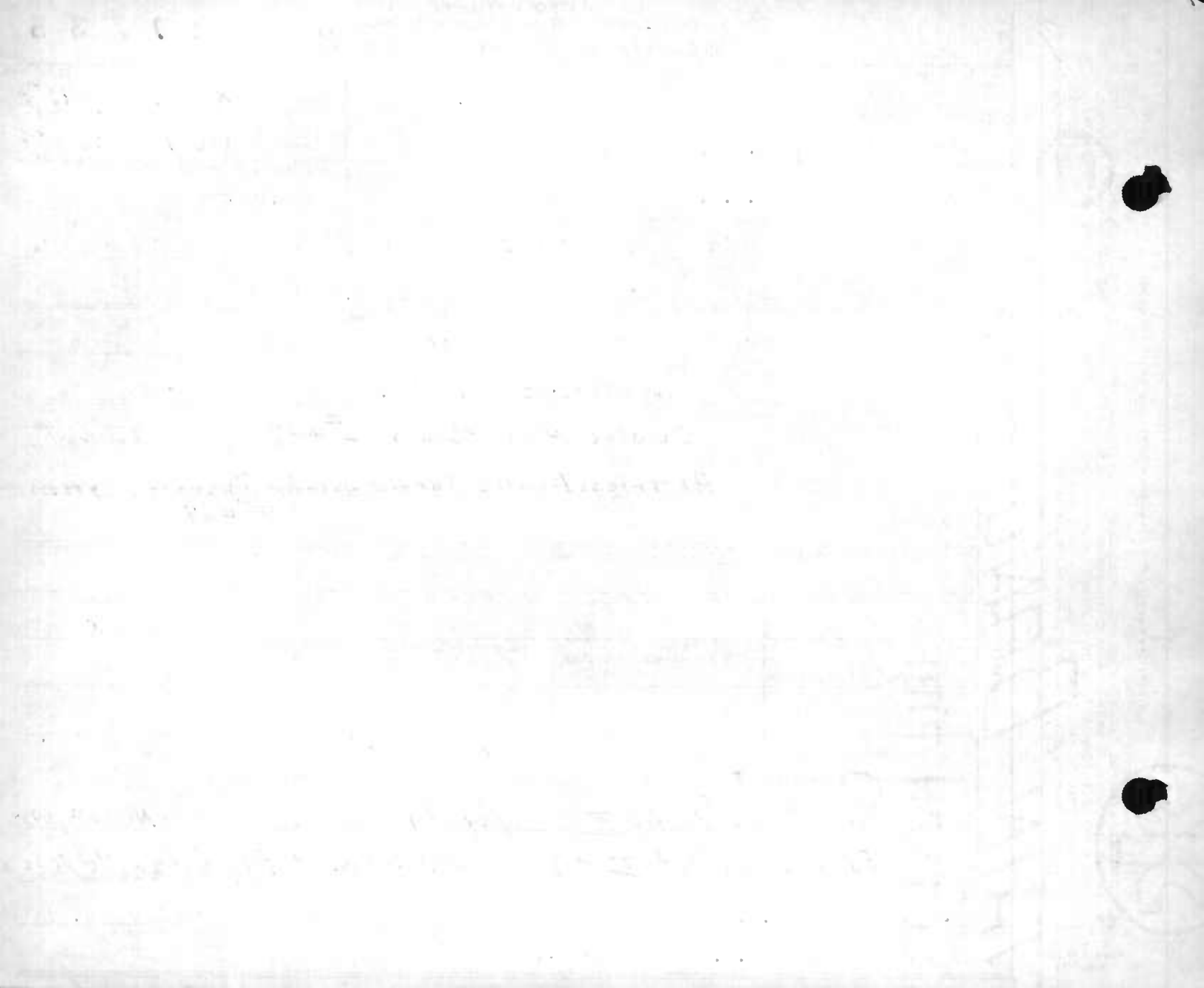
BP
DHMH - 17
(VR A15 ME (1))
30M 7/73

9
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|------------------|--|---|---|--------------------------------------|---|---------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alfred | | MIDDLE Albritton | | LAST Albritton | | 20. DATE KNOWN OF DEATH Nov. 1 19 80 | | 21. HOUR 12 40 PM | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1922 | 6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 22. DATE PRONOUNCED DEAD Nov 1 19 80 | 23. HOUR 1 09 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY Erhardt & May | |
| 13a. STATE West Virginia | | 13b. COUNTY Berkeley | 13c. CITY OR TOWN Falling Waters | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS Rt. 1 Box 109 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Henry Albritton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Daisy Hale | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 265-26-2133 | | 17. INFORMANT Mildred L. Albritton items 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia - #427</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease years #429</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Edward W. Dittus III</u> | | TITLE (SPECIFY) M. Deputy | | MEDICAL EXAMINER | | DATE SIGNED NOV 3, 1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dittus III MD | | ADDRESS 212 W. Wash St. Hagerstown, Md 21740 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 4, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Marlow Berkeley W. VA | | | |
| 24. FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt., MD | | | | 25a. DATE REC'D. BY REGISTRAR NOV 10 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Patricia Helms</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | | | 4. RACE | | | |
| CHARLES WILLIAM AUTHERS | | M | | White | | | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Feb. 28, 1911 | | 69 | | Mt. Jackson, Va. | | U. S. A. | | Washington MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Washington County Hospital | | Machinac | | Machine Mfg. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rfd. 1 Box 372 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| James David Authers | | Effie Dora Houckins | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 214-09-6279 | | Mrs. Goldie M. Authers, Rfd. 1 Box 372, Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). ACUTE BRAIN STEM HEMORRHAGE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b). 9 HOURS | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c). 4310 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). NONE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| NONE | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27, 19 80 to NOVEMBER 27, 19 80, that (II) (we) lost the deceased alive on NOVEMBER 27, 19 80, and that (III) (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| BARRY M. COHEN | | M.D. | | | | 11-27-80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| BARRY M. COHEN | | 1198 KENLY AVE HAGERSTOWN, MD, 21740 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 12-180 | | Rose Hill Cemetery | | Hagerstown, Wash. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. SIGNATURE OF REGISTRAR | | | |
| John H. Bast, Jr. | | | | DEC 1 1980 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|------------------------|---|---|--|---|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) George Alfred Barkdoll Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-4-1980 | | | 2b. HOUR 3:21 AM | | | | | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR June 25, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | 7 UNDER 1 YEAR MONTHS DAYS 67 | | 8 UNDER 24 HRS HOURS MIN 31 | | | | |
| 9 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 10 CITIZEN OF WHAT COUNTRY? USA | | | 11 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 12 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | | | |
| 13 CITY OR TOWN OF DEATH Hagerstown | | | 14 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | 15 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | | 16 KIND OF BUSINESS OR INDUSTRY Aircraft Factory | | | | | |
| 17 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a STATE Maryland | | | 17b COUNTY Washington | | | 17c CITY OR TOWN Hagerstown | | | 17d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 17e STREET ADDRESS Route 2, Box 228 | | |
| 18 FATHER'S NAME FIRST MIDDLE LAST Herman David Barkdoll | | | | | | 19 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Sheffler | | | | | | | | |
| 20 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 21 SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-3138 | | | | 22 INFORMANT ADDRESS Mrs. Anna Barkdoll, Hagerstown, Md. | | | | | | |
| 23 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours. 3 years | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 24 DATE OF OPERATION | | | | 25 CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 26 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 27 IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 28 ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 29 TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | | 30 HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 31 INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 32 PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 33 LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 34 I certify that (in this hospital) attended the deceased from Aug 19 71 , to Nov. 4 19 80 , that (in my) own opinion death occurred on the date and hour and from the causes stated above. (If yes, did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 35 SIGNATURE Richard E. Smith, M.D. | | | | | | 36 DEGREE M.D. | | 37 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 38 DATE SIGNED 11/4/80 | | | | |
| 39 PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D. | | | | | | 40 ADDRESS 1708 Oak Hill Ave, Hagerstown, Md | | | | | | | | |
| 41 BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 42 DATE Nov. 7, 1980 | | 43 NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | | 44 LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | | |
| 45 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | 46 DATE REC'D. BY REGISTRAR NOV 7 1980 | | 47 REGISTRAR'S SIGNATURE Robert McCready | | | | | | |

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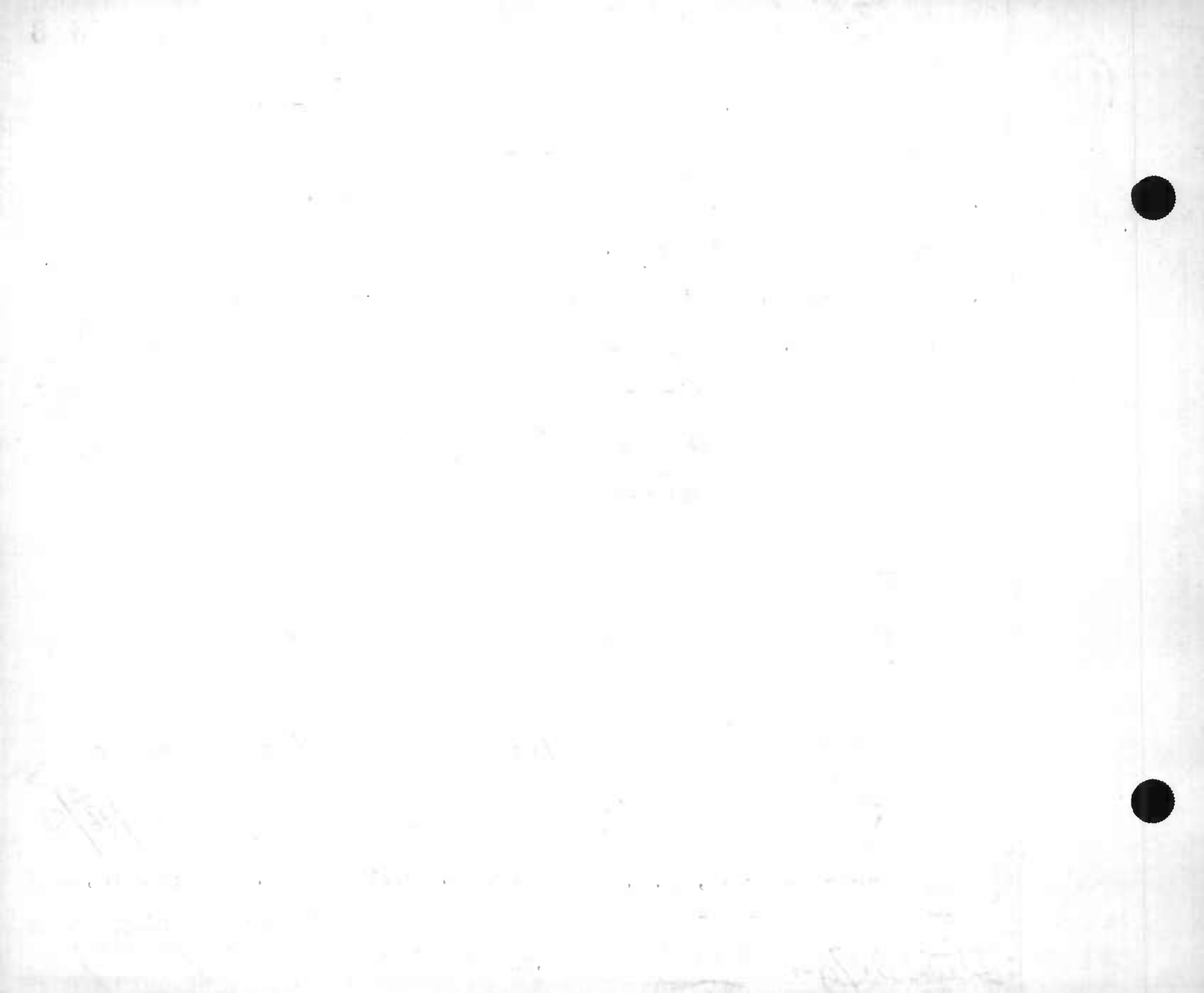
DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8029738

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 11-13-80 | | M | |
| Grace N. Barrow | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | 8-10-1896 | | 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| W.Va | | USA | | | | Washington MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | Washington Co. Hospital | | housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| W.Va | | Berkeley | | Martinsburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Charles A. Herrell | | Minnie Laura Pierce | | no | | 235-32-0380 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Richard Barrow | | Rt 1 Box 200 Martinsburg WV | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ⓔ CVA → Ⓔ hemiparesis</u> | | | |
| | | | | 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>0</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> 19 <u>80</u> to <u>11/13</u> 19 <u>80</u> , that (I) (we) lost sdw the deceased alive on <u>11/13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (and not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | Laura Waldron M.D. | | | | 11/16/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Laura Waldron, M.D. | | 138 E. Antietam St. Hagerstown, MD | | Burial | | 11-116-80 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| | | | | Rosedale | | Martinsburg, Berkeley W.Va | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Rosedale Funeral Home | | NOV 28 1980 | | | | | |
| Rt 7 Box 210 A Martinsburg W.Va | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 3 9
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|---|---|----------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Ransom Beman Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/3/80 | | 2b. HOUR 3:55 AM | |
| 3. SEX male | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 8 26 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co MD. |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Mgr. |
| 13a. STATE md | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ranso Hay Beman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Rovinsky | | | | 13e. STREET ADDRESS 6 W. Magnolia Ave. |

| | | | | | |
|--|--|---|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 370-24-4901 | | 17. INFORMANT ADDRESS Betty O. Beman, Hagerstown, Md. | |
|--|--|---|--|--|--|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock - septic / CAROIdgenic 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pneumonia - DUE TO, OR AS A CONSEQUENCE OF (c) Squamous cell carcinoma - lung | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/2/80 to 11/2/80 , that (I) (we) lost saw the deceased alive on 11/2/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE L.D. Wooster | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L.D. WOOSTER | | | | 22e. ADDRESS 1825 Howell Road - | | | |

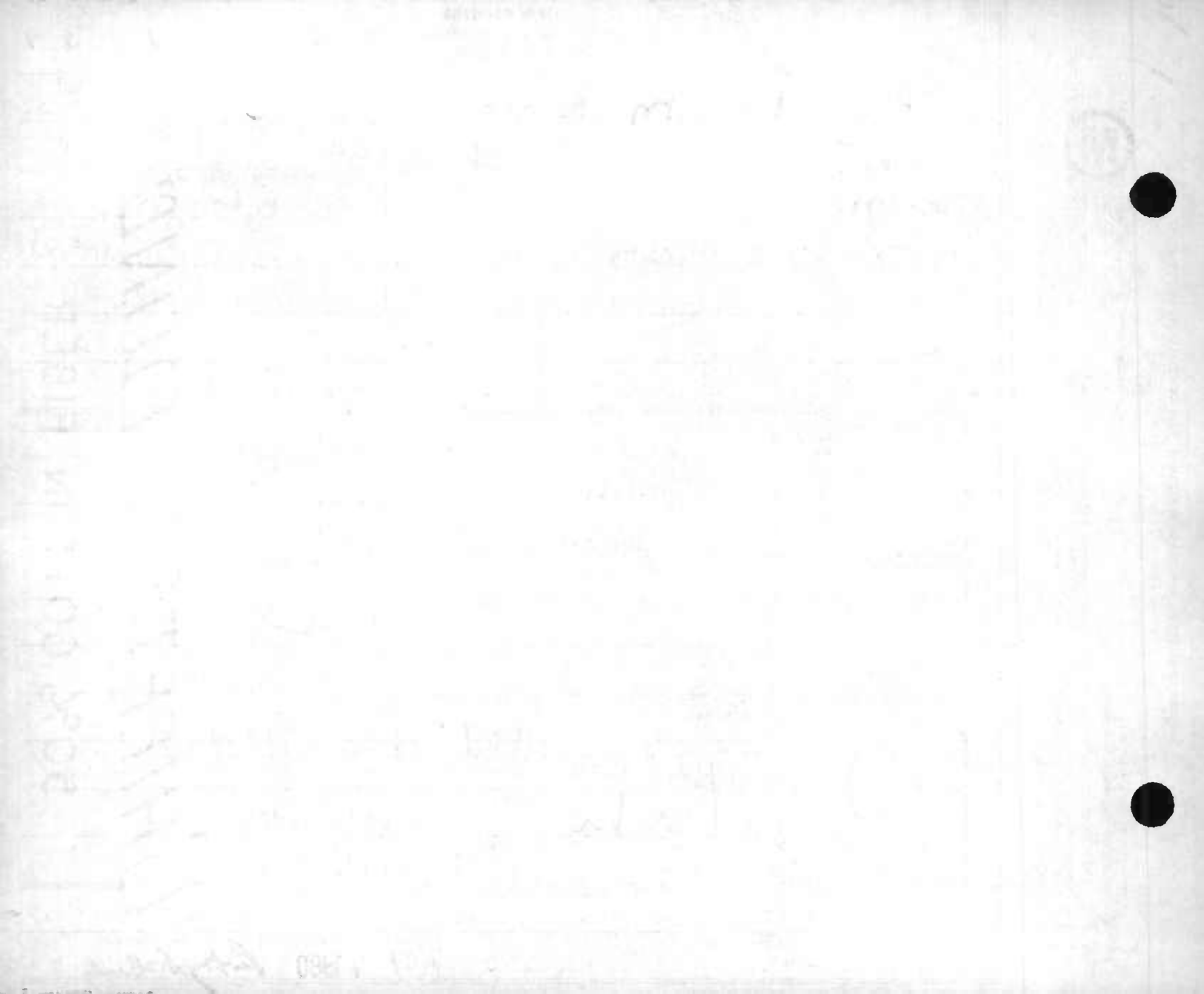
| | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 6, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | |
|---|--|----------------------------------|--|--|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | 25a. DATE REC'D. BY REGISTRAR NOV 7 1980 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 4 0

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--------|-----------------------------------|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Mary Viola BISER | | | MONTH DAY YEAR November 23, 1980 | | | 8:00P _M | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Female | White | MONTH DAY YEAR August 23, 1905 | 75 | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Park Hall, Md. | | | U. S. A. | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Hagerstown | | | Washington County Hospital | | | Housewife | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. STREET ADDRESS | | | 13b. STREET ADDRESS | | |
| Own Home | | | Rfd. 3 Box 584 | | | Rfd. 3 Box 584 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | |
| Jerome Poffenberger | | | Emma Younkens | | | 16b. SOCIAL SECURITY NO. 217-74-8114 | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia left lower lobe</i> 4810 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Burned out Guilan Bone syndrome with 1-4-80 contact</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | 21g. LOCATION STREET CITY OR TOWN COUNTY STATE | | | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-13-</i> 19 <i>77</i> , to <i>11-23-</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>11-23-</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>Thos J. Secord</i> | | | DEGREE | | | 22c. DATE SIGNED 11-24-1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 22f. ADDRESS | | |
| JOSEPH SECONDARI | | | BOONSBORO Md 21713 | | | BOONSBORO Md 21713 | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | | 11-26-80 | | | Boonsboro Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | 23e. LOCATION CITY OR TOWN COUNTY STATE | | | 23f. LOCATION CITY OR TOWN COUNTY STATE | | |
| Boonsboro, Wash. Co., Md. | | | Boonsboro, Wash. Co., Md. | | | Boonsboro, Wash. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| John H. Bast, Jr. Boonsboro, Md. 21713 | | | NOV 26 1980 | | | <i>Thos J. Secord</i> | | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

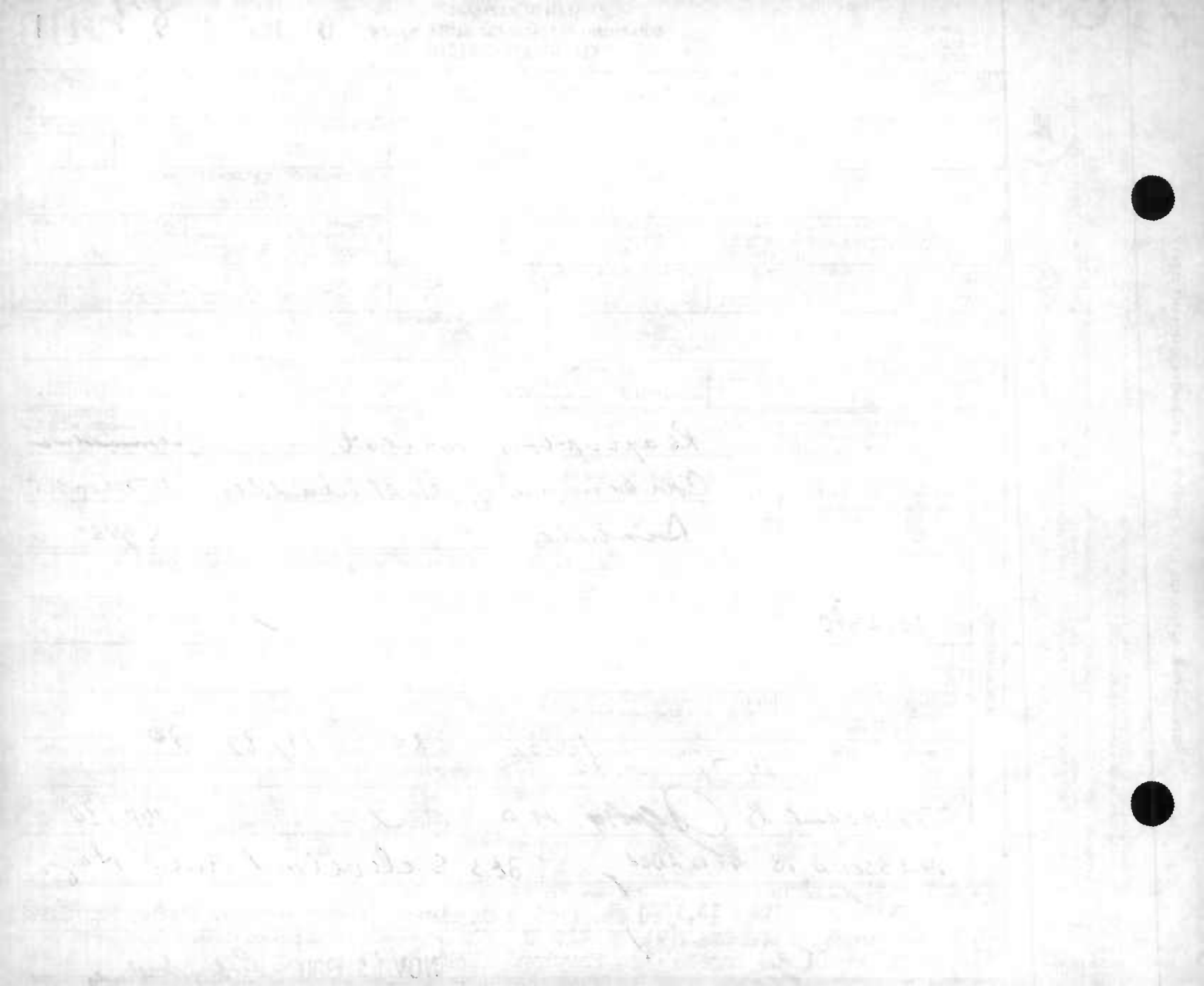
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. 80 29741 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Charles Franklin BLOYER, SR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 8, 1980 | | | | 2b. HOUR AM | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1893 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) shipping & receiving | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. CITY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 322 Buena Vista Avenue | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Frank Bloyer | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 214-09-9515 | | 17 INFORMANT ADDRESS Mr. Charles F. Bloyer, Jr., Hagerstown, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>1566</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of Gallbladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>1 month</u> <u>5-15</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION <u>10/23/80</u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/6/80</u> 19 <u>80</u> to <u>11/8/80</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/7/80</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>MASSOUD B. ALIZADEH</u> | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>11/10/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MASSOUD B. ALIZADEH</u> | | | | 22e. ADDRESS <u>363 S. Cleveland Ave. Days</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE Nov. 10, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clear Spring, Wash., Maryland | |
| 24 FUNERAL DIRECTOR <u>MINNICH FUNERAL HOME</u> <u>415 E. Wilson Blvd., Hagerstown, Maryland 21740</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>NOV 13 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>History Hall</u> | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 29742 | |
|--|------------------|--|---|---|--------------------------------|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARY LYNN BOWMAN | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Nov. 25 1980 3:45 P.M. | |
| 2a. SEX MALE | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR May 16, 1957 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD NOVEMBER 25, 80 | | 24. HOUR 4:45 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dual Highway | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) paint mixer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE West Virginia | | 13c. CITY OR TOWN Berkeley | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Route 1 Box 237A 25419 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Donald L. Bowman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shelby J. Lowman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1975-1975 | | 17. INFORMANT ADDRESS Mrs. Eileen Bowman, Falling Waters, W.Va. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #E 955 - FIREARM 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 3:45 P.M. Nov. 25 1980 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) GUNSHOT WOUND TO HEAD | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) CAR WASH | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE DUAL HIGHWAY, HAGERSTOWN, WASHINGTON, MARYLAND | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III | | TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER | | | | DATE SIGNED Nov. 26, 1980 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D. | | ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 29, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR DEC 1 1980 | | | | | | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | | |

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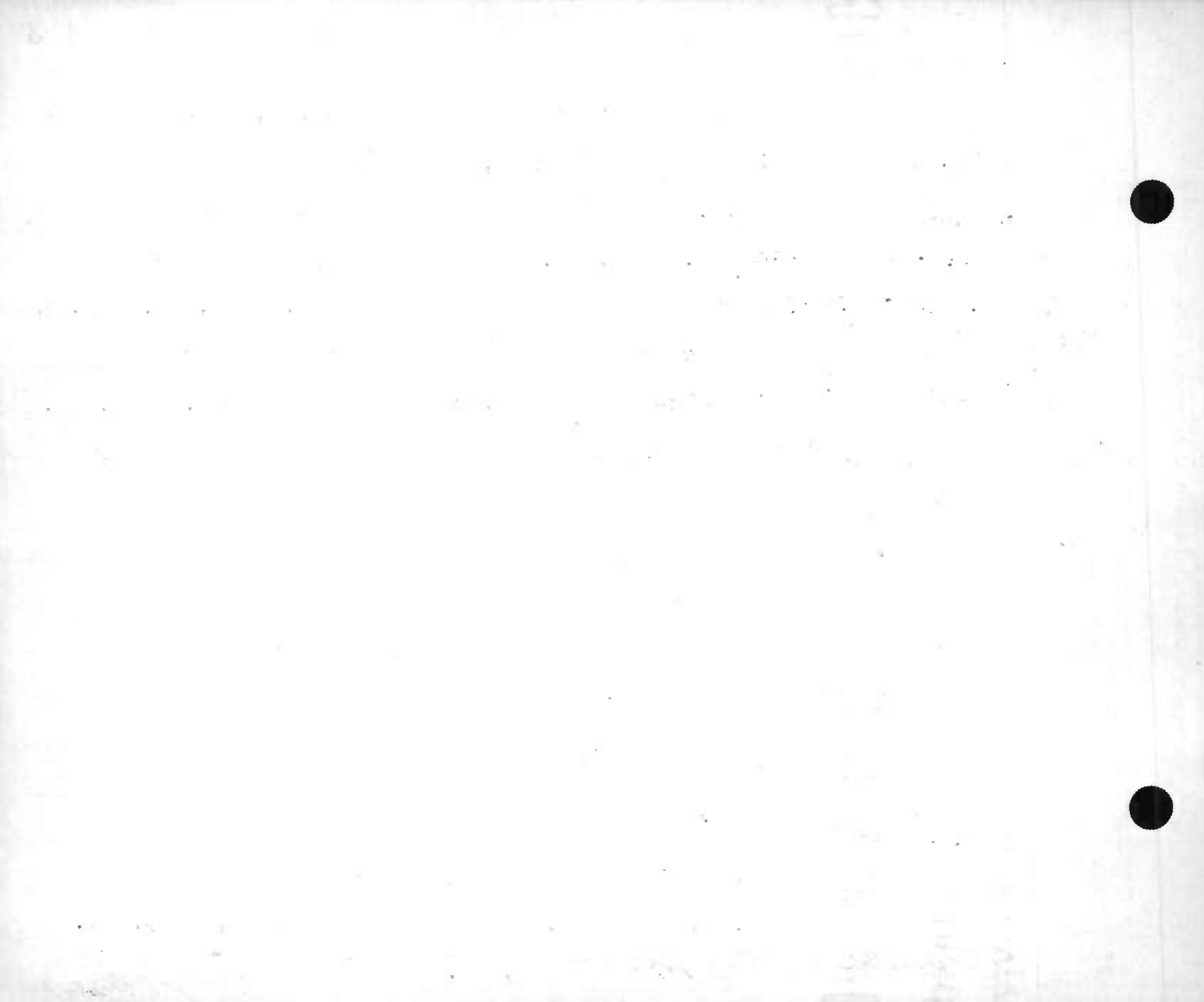
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 4 3 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Clarence Asa Boyce | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 4, 1980 | | 2b. HOUR 11:24 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 5, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1812 W. Wash. St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY Cement | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Boyce | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Munch | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 214-01-3119 | | 17. INFORMANT ADDRESS Mrs. Marie Boyce 1812 W. Wash. St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Strokes 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/29, 1970, to 11/4, 1980, that (I) (we) last saw the deceased alive on 7/09, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Barry M. Cohen, M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 11/05/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry M. Cohen, M.D. | | | | 22e. ADDRESS 1198 Kenly Ave. Hagerstown, MD, 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 6, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clearspring, Wash. Md. | |
| 24. FUNERAL DIRECTOR Donald E. Thompson Thompson Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR NOV 10 1980 | | 25b. REGISTRAR'S SIGNATURE Barry M. Cohen | |



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8029744 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ross Albert Brewer | | | | November 20, 1980 | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR July 4, 1891 | | 6 AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1115 Woodland Way | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Jacob A. Brewer | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Eyerly | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17 INFORMANT Iona G. Brewer | | 17 ADDRESS 1115 Woodland Way Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 1 day DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic CVD</u> years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Chronic Obst. Pulm. Disease, Previous myocardial infarction</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 20 March 1969, to date 19 Nov 80, that (I) (we) last saw the deceased alive on 19 Nov 80, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above. (If XX (did/did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE OF DEGREE Richard T. Binford M.D. | | | | 22c. DATE SIGNED 21 Nov. 1980 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard T. Binford, M.D. | | | | 22f. ADDRESS 1135 Potomac Ave., Hagerstown, Maryland 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-22-80 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md. | |
| 24 FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 25 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 80 29745 | |
|---|--|--|--|---|--|---|--|---|------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BERNETTA Renee BROWN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR NOV. 8 1980 | | | 2b. HOUR 8:23 P.M. | | |
| 3. SEX FEMALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR OCT 21 1961 | | 6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student - Part Time Bank | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY md Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 220 Thomas Ave | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard William Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-84-9337 | | 17. INFORMANT ADDRESS Bernard W. Brown 220 Thomas Ave Frederick, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4310 DUE TO, OR AS A CONSEQUENCE OF (b) INCREASED INTRACRANIAL PRESSURE DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 11-8-80 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-8-80 , to 11-8-80 , that (I) (we) last saw the deceased alive on 11-8-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE EDWARD B. BYRD M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 8 Nov. 80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward B. Byrd M.D. | | | | | | 22e. ADDRESS 1190 Mt. Aetna Rd. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-12-1980 | | 23c. NAME OF CEMETERY OR CREMATORY Fairview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Fred md | | | | | |
| 24. FUNERAL DIRECTOR NAME C. E. Hicks Funeral Home | | | | ADDRESS 283 W. Patrick | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 0 2 9 7 4 6

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|--|--|---|------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Helia Marie BURGAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 24 80 | | 2b. HOUR 9 05 A.M. | | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 5 4 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.V.A. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD. | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. CO. HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | |
| 12b. KIND OF BUSINESS OR INDUSTRY HOPIE | | 13a. STATE MD. | | 13b. COUNTY WASH. | | 13c. CITY OR TOWN CHILMARK | | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RD-1 | | 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. POOLIE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATIEH MARIE WIRIE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-09-2620 | | 17. INFORMANT ADDRESS MR. PHILIP BURGAN | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant years |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
 saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
 above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|--|---|--|--|--|
| 22b. SIGNATURE J. C. Eshelman md | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph C. Eshelman md | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS Washington County, Maryland | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 11-28-80 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN | | 23d. LOCATION CITY OR TOWN HAGERSTOWN | |
| 24. FUNERAL DIRECTOR THOMPSON FUNERAL HOME | | 25. DATE RECD. BY REGISTRAR DEC 1 1980 | | 26. REGISTRAR'S SIGNATURE Donald E. Thompson | | 27. REGISTRAR'S SIGNATURE THOMPSON | |

BP _____

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 4 7

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN D. BURKHOLDER | | | 2a. DATE OF DEATH Nov. 13, 1980 | | 2b. HOUR 3:15 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH Nov. 18, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Agri-Feed |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna. 13b. COUNTY Franklin 13c. CITY OR TOWN Chambersburg 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 1745 Mont Alto Road | | |
| 14. FATHER'S NAME FIRST Willis MIDDLE A LAST Burkholder | | 15. MOTHER'S MAIDEN NAME FIRST Katie MIDDLE Wingert | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 204-03-9475 | | 17. INFORMANT Mildred Burkholder Chambersburg, Pa 17201 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4349 DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN STEM INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-12 19 80 , to 11-13 19 80 , that (I) (we) last saw the deceased alive on 11-13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Jack P. Carey, MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) Jack P. Carey, MD | | 22e. ADDRESS 1190 Mt Aetna Rd Hagerstown Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Nov 16, 1980 | 23c. NAME OF CEMETERY OR CREMATORY Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Franklin Pa | |
| 24. FUNERAL DIRECTOR 152 S. 2nd St. Chambersburg PA | | 25a. DATE REC'D. BY REGISTRAR NOV 18 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | |



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JACK P. CUNY, MD 11:20 PM FROM 24 HAZARD 714
JACK P. CUNY, MD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 29748

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) Albert H Caesar, Jr. | | 2a. DATE OF DEATH MONTH DAY YEAR 11-23-80 | |
| 3 SEX M | | 4 RACE White | |
| 5 DATE OF BIRTH MONTH DAY YEAR 8 18 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jersey City N.J. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD. | |
| 10 CITY OR TOWN OF DEATH Hagerstown Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cottonville Nursing Center | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. VP | | 12b. KIND OF BUSINESS OR INDUSTRY Banner Business Products | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md | | 13b. COUNTY Wash | |
| 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 1401 The Terrace | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Albert H. Caesar Sr. | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnus Rae Sullivan | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 087-09-5928 | |
| 17 INFORMANT ADDRESS Mrs. Ruby Caesar, 1401 The Terrace | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>atherosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) C.O.P.D. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>13 Nov 80</u> to <u>19 80</u> , that (I) (we) lost saw the deceased alive on <u>13 Nov 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>H N Weeks</u> | | 22c. DATE SIGNED 11/26/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H N Weeks | | 22e. ADDRESS 580 Northern Ave Hagerstown Md | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/26/80 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Mausoleum | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md. | |
| 24 FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md. | | 25 DATE REC'D BY REGISTRAR NOV 28 1980 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8029749 | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Elmer | | MIDDLE Stiles | | LAST Campbell | | 2a. DATE OF DEATH MONTH DAY YEAR November 26, 1980 | | 2b. HOUR 4:00 A M | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 23 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Keedysville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Keedysville | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec. Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Board of Ed. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Keedysville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1 Keedysville | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander McDermich Campbell | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Snyder | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 199-07-9590 | | 17. INFORMANT ADDRESS Thomas Campbell 900 Noland Dr. Hag., MD 21740 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>MITRAL VALVE PROLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK YEARS YEARS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (I myself) attended the deceased from <u>JAN. 9</u> , 19 <u>80</u> , to <u>NOV. 3</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Nov. 3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I myself) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Edward W. Dittus</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Nov. 28, 1980 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D. | | | | 22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Nov. 29, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Greenalwn Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD | | | |
| 24. FUNERAL DIRECTOR NAME Osborne Funeral Homes P.O. Box 348 Wmspt., MD | | | | | | 25. DATE REC'D. BY REGISTRAR DEC 5 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Robert A. Bailey</i> | | | |

SECRET

121

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible text block]

DATE: [Illegible]
[Illegible text block]

[Handwritten signature]

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death.

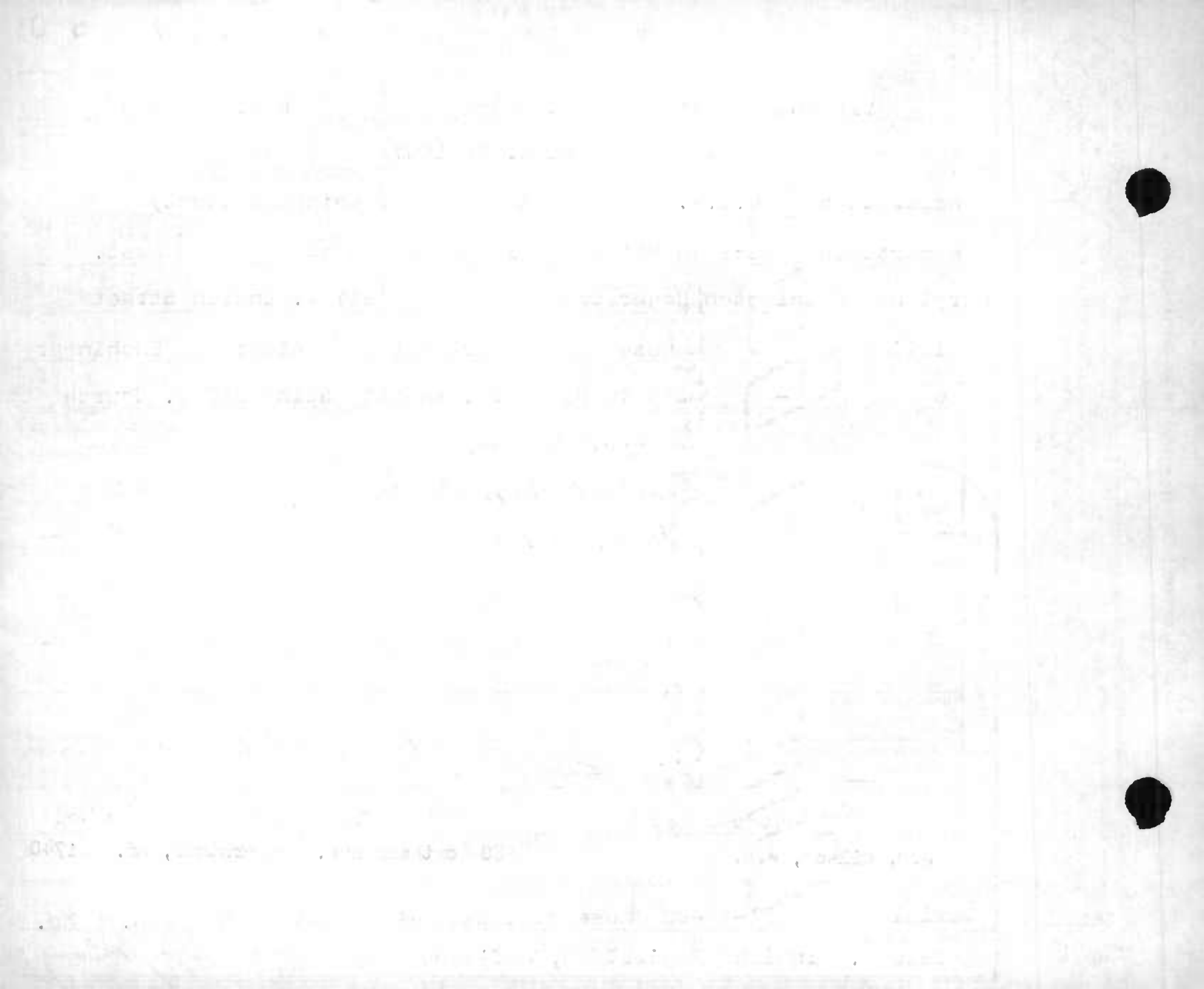
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8029750 | |
|--|--|--|--|---|--|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Virginia Ada Carmack | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 6 1980 | | | 2b. HOUR M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 26 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | | 12b. KIND OF BUSINESS OR INDUSTRY Rest. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 517 W. Church Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Hose | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Aldora Enshinger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS Mrs. Annette Stine 517 W. Church st | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>min</u> <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>70</u> , to <u>6 Nov.</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4 Nov.</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>J. D. Wilson, M.D.</u> DEGREE 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.D. Wilson, M.D. | | | | | | 22c. DATE SIGNED 11/7/80 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. ADDRESS 580 Northern Ave. Hagerstown, Md. 21740 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-10-80 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich | | | | 305 N. Potomac St. Hagerstown, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Barbara McCready</u> | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 5 1

REG. NO.

| | | | | | |
|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 1627 M | |
| PAUL LEROY CARPENTER | | 11-10-80 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| M | White | MONTH DAY YEAR | 79 YRS | IF UNDER 24 HRS | |
| | | 10 9, 1901 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Washington County, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | Washington County Hospital | | | | |
| 13a. STREET ADDRESS | | | 13b. INSIDE CITY LIMITS? | | |
| 121 Pennsylvania Avenue | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Henry Carpenter | | Blanche Barnhart | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 214-09-7705 | | 104 Wash. St. Richard B. Carpenter, Hancock, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Abdominal Carcinomatosis | | | | | Months |
| DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of colon | | | | | Months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 11-8-80 | | Intestinal Obstruction | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| HOUR A.M. MONTH DAY YEAR | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9-29, 19 80, to 11-10, 19 80, that (1) (we) lost | | | | | |
| saw the deceased alive on 11-10, 19 80, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| E. Hawbaker M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 11-11-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 11/13/80 | | Rest Haven Cemetery Hagerstown, Wash., Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Rest Haven Funeral Chapel, Inc., Hag., Md. | | 11-14-1980 | | [Signature] | |

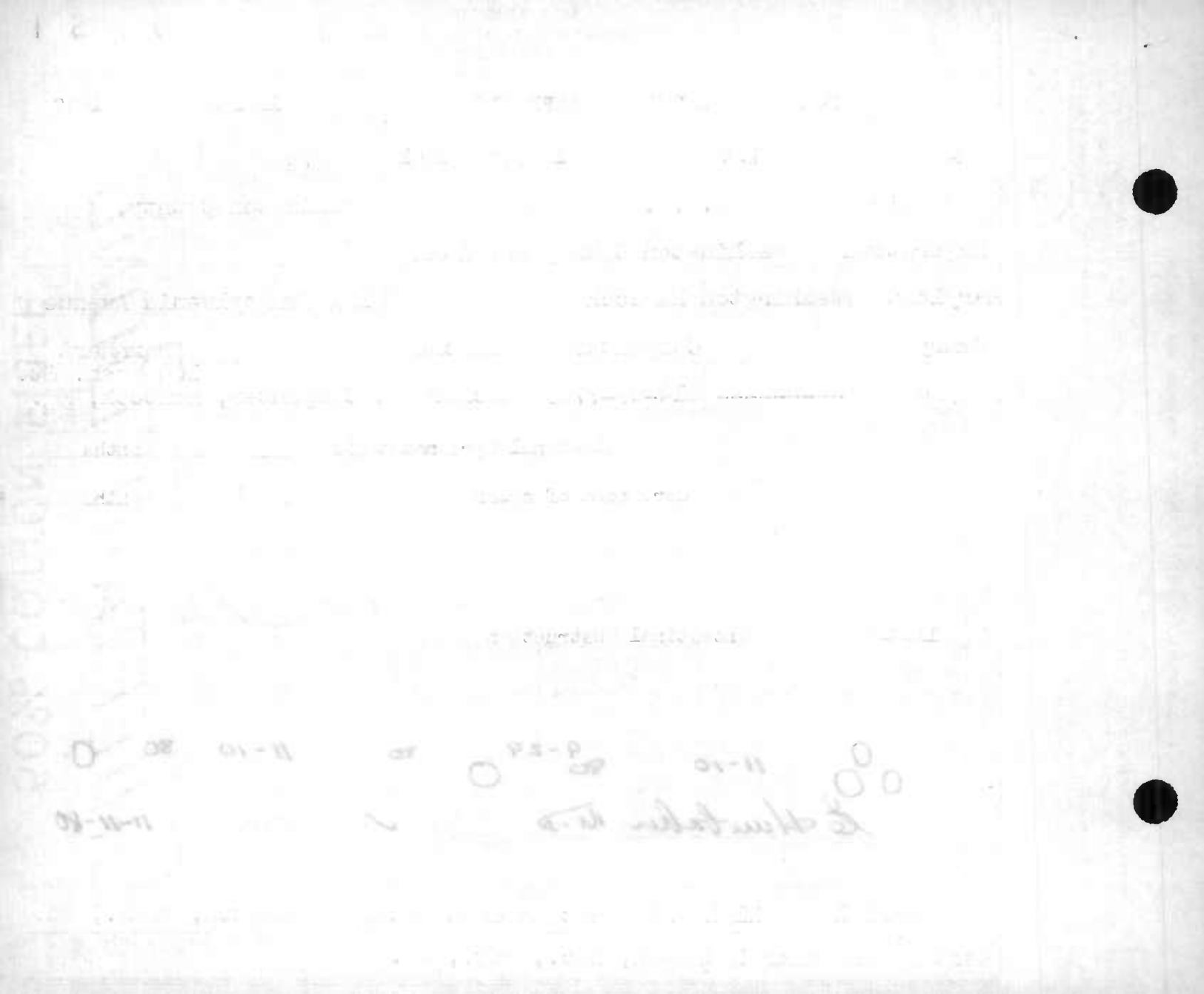
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 80 29752 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Jessie Ellen Coffey | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 14, 1980 | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Frederick Middletown | | 13c. STREET ADDRESS 7414 Mason Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Mullarkey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Margaret Dowd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 130 22 1527 | | 17. INFORMANT ADDRESS Eileen T. Schultze see # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO 4140 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARRYTHMIA (ATRIAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) FIBRILLATION) ARTERIOSCLEROTIC HEART PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) OLD AGE DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/28 19 80 , to 11/14 19 80 , that (I) (we) last saw the deceased alive on 11/7 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE C. Amarillo | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/14/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO | | 22e. ADDRESS 127 KING ST HAGERSTOWN MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-17-80 | | 23c. NAME OF CEMETERY OR CREMATORY Long Island Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pinelawn Long Island, N. Y. | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich | | ADDRESS 305 N. Potomac St. Hagerstown, Maryland | | 25a. DATE REC'D BY REGISTRAR NOV 21 1980 REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION



NOT RECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 80 29753 | | |
|---|--|-----------------------------|---|--|------------------------------------|--|--|---|-------------------------------------|---|------|---------|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR |
| John | | | H. | Crone | 11 8 80 | | | 2:47 | | | P.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| m | | White | | MONTH DAY YEAR | | 88 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Winchester, Ky. | | USA | | | | Washington County MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | Avalon Manor Nursing Home | | | architect | | | father | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | |
| md. | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Basswood Rd. 7028 Bassford Rd. | | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | |
| John W. Crone | | | | Louise M. Stalder | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | | ADDRESS | | | |
| Yes | | | | WWI | | 219-34-7847A | | | Leila L. Crone (Wife) Same as above | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage | | | | | | | | | | 4 hrs | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| (b) Arteriosclerosis - Generalized | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| Arteriosclerotic Heart Disease | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from 8-8, 1980, to 10-11, 1980, that (I) (we) saw the deceased alive on 11-8-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| Lloyd A. Hoffman | | | M.D. | | | | | | 11/8/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | |
| Lloyd A. Hoffman | | | 1147 Oak Hill Ave. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | | 11-12-80 | | Ft. Lincoln Cem. | | | Brentwood - Pr. Geo. Md. | | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | | NOV 17 1980 | | Lloyd A. Hoffman | | | | |

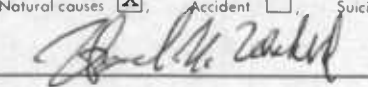



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. THIS CERTIFICATE MUST BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---------|--|---|--|-----------------------------------|--|--------------------|---|----------|--|---------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Richard Hartle Delaughter | | | | 20. DATE KNOWN OF DEATH ESTI- MATED | | 21. NOV. 19 80 | | 22. HOUR P M 6:00 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 9. DATE PRONOUNCED DEAD | 10. MONTH DAY YEAR | 11. NOV. 20 19 80 | 12. HOUR | 13. 4:00 | 14. P M |
| 15. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 16. CITIZEN OF WHAT COUNTRY? U.S.A. | | 17. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 18. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD. | | | | | |
| 19. CITY OR TOWN OF DEATH Hagerstown | | 20. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 329 S. Cannon Avenue | | | | 21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 22. KIND OF BUSINESS OR INDUSTRY | | | |
| 23. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 24. STATE Maryland | | 25. COUNTY Washington | | 26. CITY OR TOWN Hagerstown | | 27. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 28. STREET ADDRESS 329 S. Cannon Avenue | | | |
| 29. FATHER'S NAME Charles H. Delaughter | | | | | | 30. MOTHER'S MAIDEN NAME Mary Hartle | | | | | |
| 31. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 32. SOCIAL SECURITY NO. WW 11 | | 33. INFORMANT Patricia A. Delaughter, Daughter | | 34. ADDRESS | | | | | |
| 35. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Code 410 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | 36. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | |
| 37. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 38. DATE OF OPERATION | | 39. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 40. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 41. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 42. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 43. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 44. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 45. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 46. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 47. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| 48. ACTUAL SIGNATURE  | | 49. TITLE (SPECIFY) Deputy | | 50. MEDICAL EXAMINER | | 51. DATE SIGNED 11/21/80 | | | | | |
| 52. EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. | | 53. ADDRESS 580 Northern Ave., Hagerstown | | | | | | | | | |
| 54. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 55. DATE 11/22/80 | | 56. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 57. LOCATION Hagerstown, Washington, Md. | | | | | |
| 58. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md. | | | | 59. DATE REC'D. BY REGISTRAR NOV 25 1980 | | 60. REGISTERING SIGNATURE  | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8029755 | | | |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elizabeth DIFFENDALL | | | | 2a DATE OF DEATH MONTH DAY YEAR November 10, 1980 | | | 2b. HOUR M |
| 3 SEX female | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR May 25, 1893 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) office work | | 12b. KIND OF BUSINESS OR INDUSTRY insurance | |
| 13a STATE Maryland | | | | 13b. CITY OR TOWN Washington | | 13c. STREET ADDRESS Route 2, Box 244 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Martin L. Houck | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy E. Grove | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-74-7136 | | 17 INFORMANT ADDRESS John Palmer, Sr., Rt. 2, Smithsburg, Md. 21783 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HYPERTENSIVE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIOVASCULAR DISEASE</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>OLD AGE</u> | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 4</u> 19 <u>76</u> , to <u>NOV 10</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>NOV 5</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>R. Amarillo</i> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/11/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO | | 22e ADDRESS 127 KING ST HAGERSTOWN MD 21740 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 14, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | |
| 24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 17 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Anthony McCurdy</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-400 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 80 29756 | |
|---|--|---|--|--|--|--|--|--|---------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS FELIX DOWNEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 3, 1980 | | | 2b. HOUR 9 A.M. | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 13, 1915 | | 6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON CO., MD. | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON CO. HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY MACK TRUCK | | | |
| 13a. STATE PENNA. | | | | | | 13b. COUNTY FRANKLIN | | 13c. CITY OR TOWN GREENCASTLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN - DOWNEY | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu - NUNN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 1942-1945 136-07-4933 | | 17. INFORMANT ADDRESS DOROTHY DOWNEY - RD1, GREENCASTLE, PA. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4331 Hypoxic encephalopathy DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured internal carotid artery DUE TO, OR AS A CONSEQUENCE OF (c) Severe anterior division carotid artery CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 10/29/80 or 10/31/80 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Debridement of infected plaque and abscess | | | | 19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/31 , 19 80 , to 11/2 , 19 80 , that (I) (we) last saw the deceased alive on 11/2 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John R. Marsh, M.D. | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/3/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH, M.D. | | | | | | 22e. ADDRESS 239 N. POTOMAC ST. HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE NOV. 6/80 | | 23c. NAME OF CEMETERY OR CREMATORY Hillside Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Plainfield, N.J. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS A.E. Mennich - GREENCASTLE, PA. | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 6 1980 | | 25b. REGISTRAR'S SIGNATURE Anthony Helwig | | | |

C.E. Whinnell - Greenacres Rd.
Barnes NW9 6JZ Hillside Court
Plaintiff vs Defendant

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 5 7

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) John Cooper Eliot | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 7, 1980 | | 2b. HOUR 12:15 A.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1962 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (IFE)) - | |
| 12b. KIND OF BUSINESS OR INDUSTRY - | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2705 Silverdale Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Eliot | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Hewitt | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 216 88 7171 | | 17. INFORMANT ADDRESS Mr. and Mrs. John Eliot Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lung 2377 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Quadriplegia (c) Neurofibromatosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: - | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/78 19 79 to 11/78 19 80 , that (I) (we) lost saw the deceased alive on 11/78 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kyung S. Kim DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11/7/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kyung S. Kim, M.D. | | | | 22e. ADDRESS Western Maryland Hospital Center 1500 Pennsylvania Ave., Hagerstown, Md. 217 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Nov. 7 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Wash. Md. | | 24. FUNERAL DIRECTOR NAME Dennis Davis ADDRESS Davis Funeral Home, Smithsburg, Md. 21783 | | | |
| 25a. DATE REC'D. BY REGISTRAR NOV 12 1980 | | | | | |

BP_____

DHMH-16 25M
(VRA 15. 4) 1/79

25a. DATE REC'D. BY REG
NOV 12 1980

3 3 3 1

THE
LIBRARY
OF THE
MUSEUM OF
ART AND
ARCHAEOLOGY
OF THE
UNIVERSITY OF
CHICAGO

John
Gopher
Ellis

NOV 15 1980



Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 5 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nellie Blanche Exline | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 17, 1980 | | | 2b. HOUR M | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 3 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD. | | | | |
| 10 CITY OR TOWN OF DEATH Hancock | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #1 Box 126 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hancock | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. #1 Box 126 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George L. Ritchey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Jane Foor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 213 74 6615 | | 17. INFORMANT ADDRESS Elmer H. Exline same as deceased | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 5140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive pneumonia & em. Dehisc. Tail elms.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Syed. Shah MD</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SYED. SHAH MD | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 11-21-80 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Presbyterian | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rt. 1 Hancock Wash. Md. | | | |
| 24. FUNERAL DIRECTOR NAME <u>Richard J. Exline</u> | | | | | 25. WEDDED BY REGISTRAR? (SEE INSTRUCTIONS) NOV 20 1980 | | | | | |



1908

REG. NO.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP_____

DHMH - 17
(VR A15 ME (5))
30M 7/73



TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

DATE: [Illegible]
[Illegible]

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

DATE: [Illegible]
[Illegible]

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

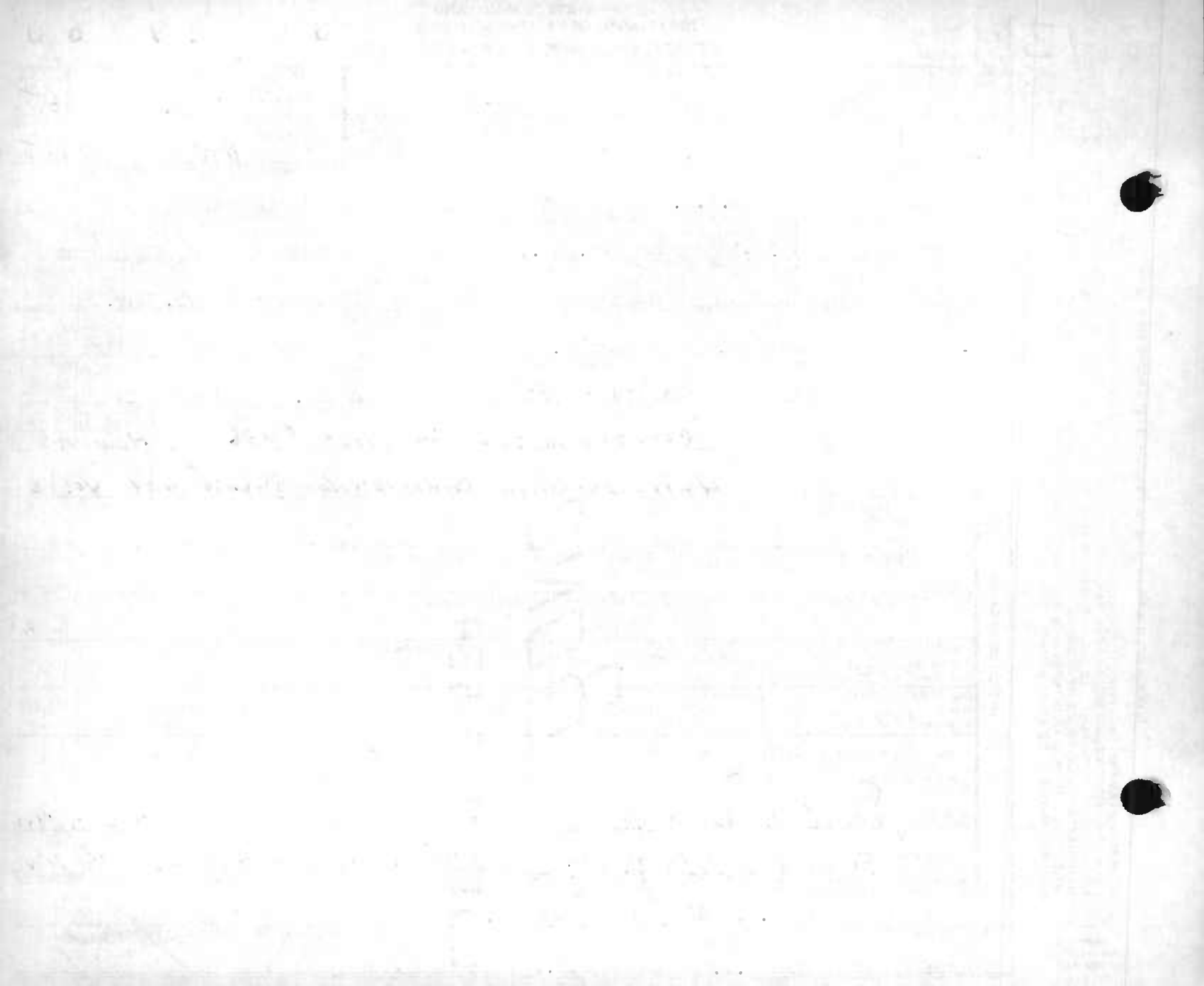
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 29760 | |
|--|--|------------------|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Henry Garrish | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Nov. 1 19 80 6 PM | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR July 24, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Nov 2 19 80 12 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1631 Sherman Ave. Hag., MD 21740 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) assembler | | 12b. KIND OF BUSINESS OR INDUSTRY Pangborne | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1631 Sherman Ave. Hag., MD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Benjamin Garrish | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Elizabeth Rice | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 217-10-3495 | | 17. INFORMANT Joseph Garrish Jr. | | | | item # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident #436</u> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease 499 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Edward W. Dix Jr.</u> | | | | TITLE (SPECIFY) <u>Deputy</u> | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Edward W. Dix Jr. MD</u> | | | | ADDRESS <u>212 W. Wash. St. Hagerstown, MD 21740</u> | | | | DATE SIGNED <u>Nov 3, 1980</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE Nov. 5, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD | |
| 24. FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt., MD | | | | | | 25a. DATE REC'D. BY REGISTRAR Nov 10 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Anthony...</u> | | | |

MEDICAL CERTIFICATION



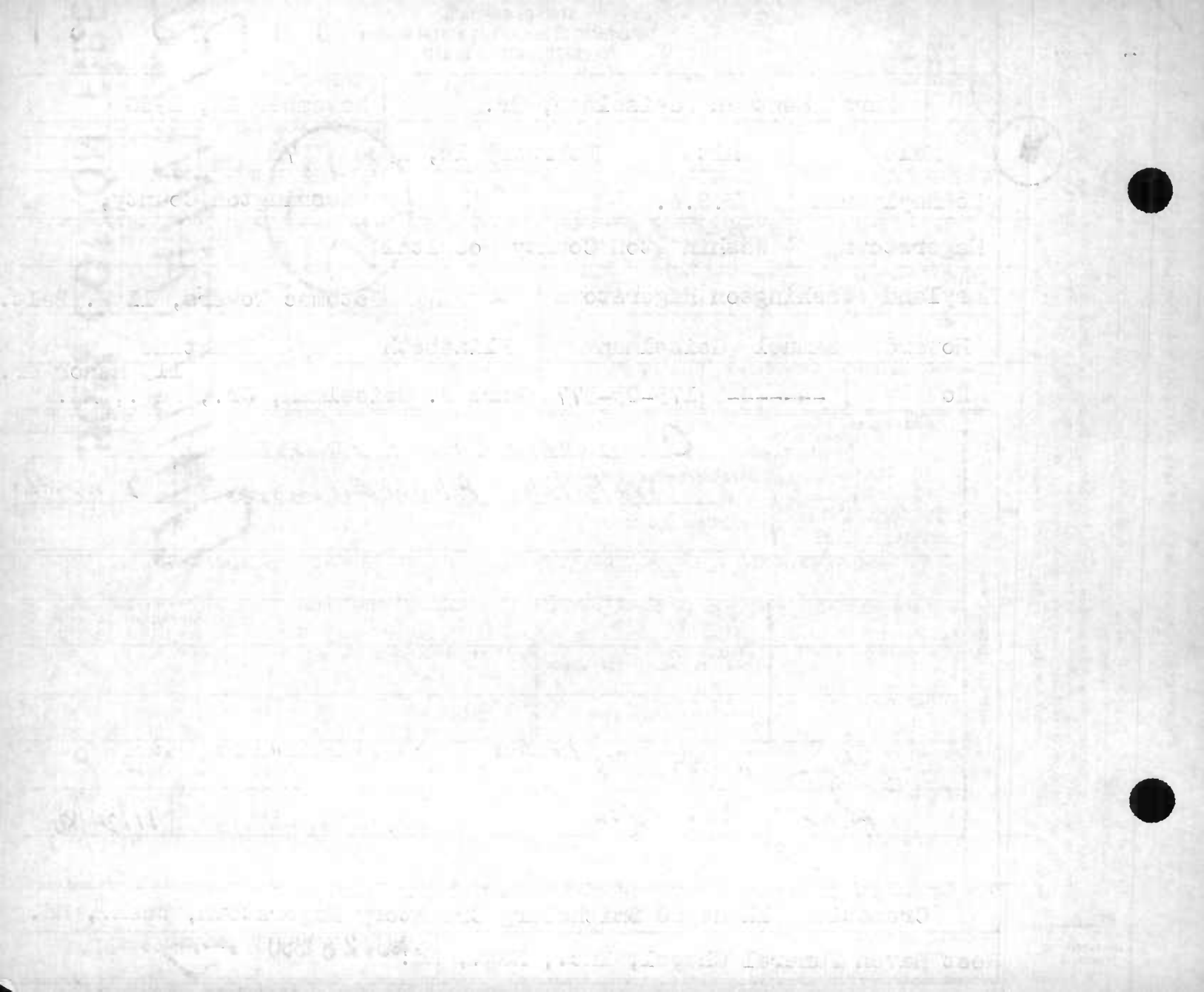
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 6 1 | | | |
|---|--|--|--|---|--|--|--|
| FOR 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Ezra Sentman Geiselman, Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 22, 1980 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR February 14, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washin gton County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard Samuel Geiselman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth May Hanstine | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. ----- 173-03-3778 | | 17. INFORMANT ADDRESS 119 Manor Dr. Ezra S. Geiselman, Jr., Hag., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>80</u> , to <u>11-22</u> , 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>11-22</u> , 19 <u>80</u> , and that if (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>11/24/80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 11/24/80 | | 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory Hagerstown, Wash., Md. | | 23d. LOCATION CITY OR TOWN COUNTY | |
| 24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md. | | | | 25a. DATE OF FILING NOV 28 1980 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |





1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 29762

REG. NO.

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Adrian Gochenour, Jr | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 03 80 | | 2b. HOUR 8:35p M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 04 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 9. CITIZEN OF WHAT COUNTRY? US | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 12. CITY OR TOWN OF DEATH Hagerstown | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Ctr | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance adjuster | | 15. KIND OF BUSINESS OR INDUSTRY |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wash 13c. CITY OR TOWN Hagerstown | | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS 345 Daycotah Ave. |
| 19. FATHER'S NAME FIRST MIDDLE LAST James Adrian Gochenour, Sr. | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora L. Coffman | | 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No | |
| 22. SOCIAL SECURITY NO. 214-16-0464 | | 23. INFORMANT ADDRESS Evelyn Gochenour, 345 Daycotah Ave. | | | |

| | | |
|---|--|--|
| 1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Rectum DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Years |
|---|--|--|

| | | | | | |
|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/16/80 to 11/3/80, that (I) (we) last saw the deceased alive on 11/3/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kyung S. Kim | | DEGREE MD | | 22c. DATE SIGNED 11/3/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KYUNG S KIM | | 22e. ADDRESS 1500 Penna Ave, Hagerstown, Md. 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/6/80 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN Hagerstown | | COUNTY Wash., | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR NOV 7 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Anthony McHenry | |

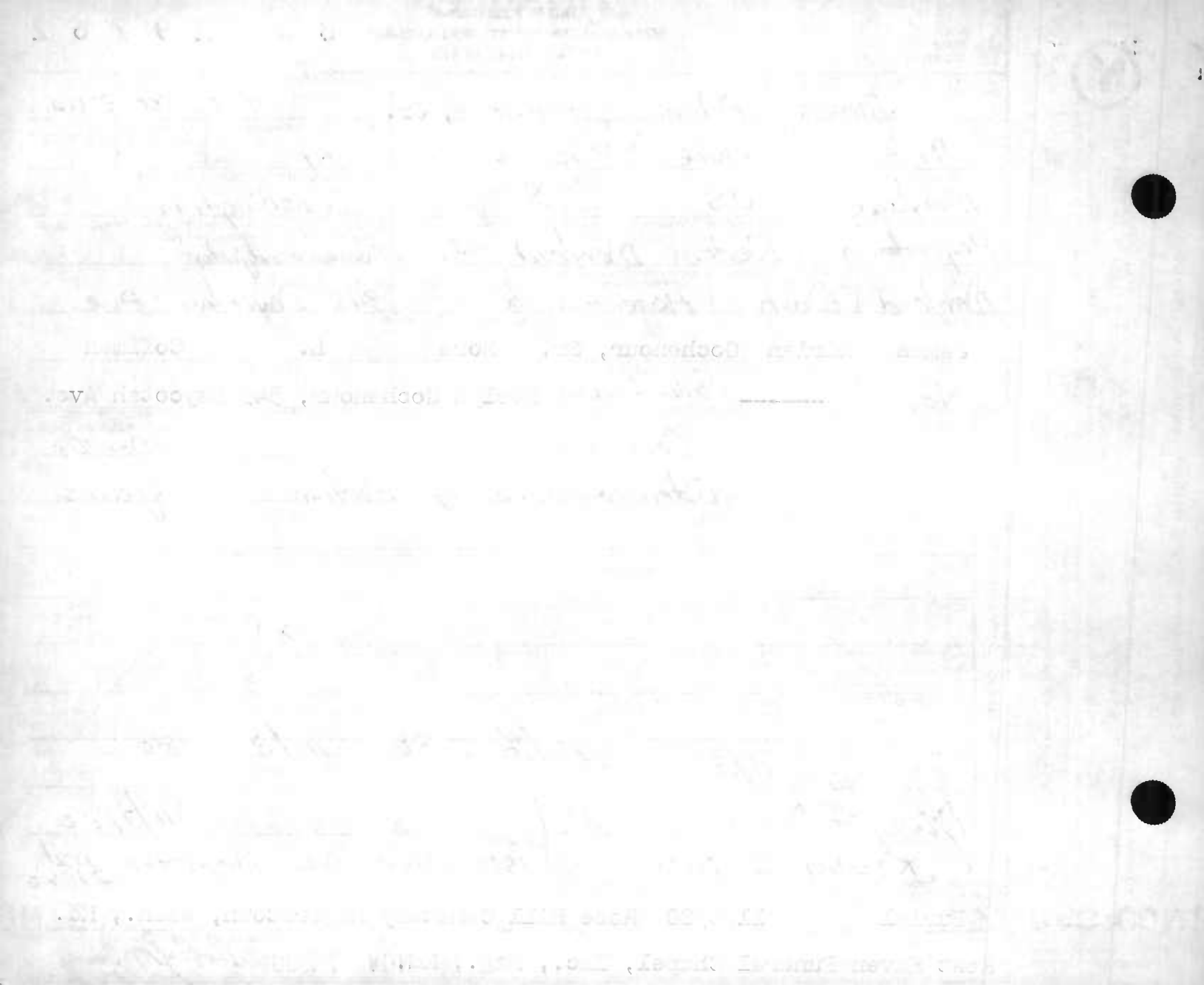
BP

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 17
(VR A 15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 80 29763 | |
|---|--|--|--|--|--|--|--|--|--|---------------------------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Costello Golightly | | | | | | | | | | 2b. DATE KNOWN OF DEATH 11/16/1980 | |
| 3. SEX Female | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 11/16/80 | |
| 4. RACE white | | | | | | | | | | 2d. HOUR 6 AM | |
| 5. DATE OF BIRTH MONTH DAY YEAR 11/5/92 | | | | | | | | | | 2e. HOUR 10 | |
| 6. AGE (IN YEARS) (LAST BIRTHDAY) 88 YRS | | | | | | | | | | 2f. DATE PRONOUNCED DEAD 11/16/80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | | | | | | | 2g. DATE PRONOUNCED DEAD 11/16/80 | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 2h. DATE PRONOUNCED DEAD 11/16/80 | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2i. DATE PRONOUNCED DEAD 11/16/80 | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Washington | | | | | | | | | | 2j. DATE PRONOUNCED DEAD 11/16/80 | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | | | | | | | 2k. DATE PRONOUNCED DEAD 11/16/80 | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 950 Kenwood Drive | | | | | | | | | | 2l. DATE PRONOUNCED DEAD 11/16/80 | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | | | | | | | | | 2m. DATE PRONOUNCED DEAD 11/16/80 | |
| 12b. KIND OF BUSINESS OR INDUSTRY fruit plant | | | | | | | | | | 2n. DATE PRONOUNCED DEAD 11/16/80 | |
| 13a. STATE Virginia | | | | | | | | | | 2o. DATE PRONOUNCED DEAD 11/16/80 | |
| 13b. COUNTY Clarke | | | | | | | | | | 2p. DATE PRONOUNCED DEAD 11/16/80 | |
| 13c. CITY OR TOWN Berryville | | | | | | | | | | 2q. DATE PRONOUNCED DEAD 11/16/80 | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 2r. DATE PRONOUNCED DEAD 11/16/80 | |
| 13e. STREET ADDRESS Route 1 | | | | | | | | | | 2s. DATE PRONOUNCED DEAD 11/16/80 | |
| 13f. ZIP CODE 22611 | | | | | | | | | | 2t. DATE PRONOUNCED DEAD 11/16/80 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James R. Costello | | | | | | | | | | 2u. DATE PRONOUNCED DEAD 11/16/80 | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Symmons | | | | | | | | | | 2v. DATE PRONOUNCED DEAD 11/16/80 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | 2w. DATE PRONOUNCED DEAD 11/16/80 | |
| 16b. SOCIAL SECURITY NO. | | | | | | | | | | 2x. DATE PRONOUNCED DEAD 11/16/80 | |
| 17. INFORMANT Mrs. Catherine Campbell, Bunker Hill, W.V. | | | | | | | | | | 2y. DATE PRONOUNCED DEAD 11/16/80 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease - 429 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | 2z. DATE PRONOUNCED DEAD 11/16/80 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | 2aa. DATE PRONOUNCED DEAD 11/16/80 | |
| 19a. DATE OF OPERATION | | | | | | | | | | 2ab. DATE PRONOUNCED DEAD 11/16/80 | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 2ac. DATE PRONOUNCED DEAD 11/16/80 | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 2ad. DATE PRONOUNCED DEAD 11/16/80 | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 2ae. DATE PRONOUNCED DEAD 11/16/80 | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 2af. DATE PRONOUNCED DEAD 11/16/80 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | 2ag. DATE PRONOUNCED DEAD 11/16/80 | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 2ah. DATE PRONOUNCED DEAD 11/16/80 | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 2ai. DATE PRONOUNCED DEAD 11/16/80 | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | 2aj. DATE PRONOUNCED DEAD 11/16/80 | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 2ak. DATE PRONOUNCED DEAD 11/16/80 | |
| 22b. TITLE (SPECIFY) M.D. ocp MEDICAL EXAMINER | | | | | | | | | | 2al. DATE PRONOUNCED DEAD 11/16/80 | |
| 22c. ACTUAL SIGNATURE H. N. WEEKS, M.D. | | | | | | | | | | 2am. DATE PRONOUNCED DEAD 11/16/80 | |
| 22d. EXAMINER'S NAME (TYPE OR PRINT) H. N. WEEKS, M.D. | | | | | | | | | | 2an. DATE PRONOUNCED DEAD 11/16/80 | |
| 22e. ADDRESS 580 Northern Ave. Hagerstown, Md. | | | | | | | | | | 2ao. DATE PRONOUNCED DEAD 11/16/80 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | | | | | | | 2ap. DATE PRONOUNCED DEAD 11/16/80 | |
| 23b. DATE Nov. 19, 1980 | | | | | | | | | | 2aq. DATE PRONOUNCED DEAD 11/16/80 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery | | | | | | | | | | 2ar. DATE PRONOUNCED DEAD 11/16/80 | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Winchester, Virginia | | | | | | | | | | 2as. DATE PRONOUNCED DEAD 11/16/80 | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | 2at. DATE PRONOUNCED DEAD 11/16/80 | |
| 25a. DATE REC'D. BY REGISTRAR NOV 21 1980 | | | | | | | | | | 2au. DATE PRONOUNCED DEAD 11/16/80 | |
| 25b. REGISTRAR'S SIGNATURE H. N. WEEKS | | | | | | | | | | 2av. DATE PRONOUNCED DEAD 11/16/80 | |



CONFIDENTIAL - SECURITY INFORMATION

NOV 2 1960

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80

29764

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GILALYS Viola GORDON | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 28, 1980 | | 2b. HOUR 12:45 P |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Hagerstown | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS RFD-4 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hugh Frush | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rhodes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 219-20-0160 | | 17. INFORMANT ADDRESS Mr. Larry Gordon Hag. Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:4100
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.b) *Myocardial Infarction*
c) *Anterior wall heart disease*
DUE TO, OR AS A CONSEQUENCE OFAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1d

yes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

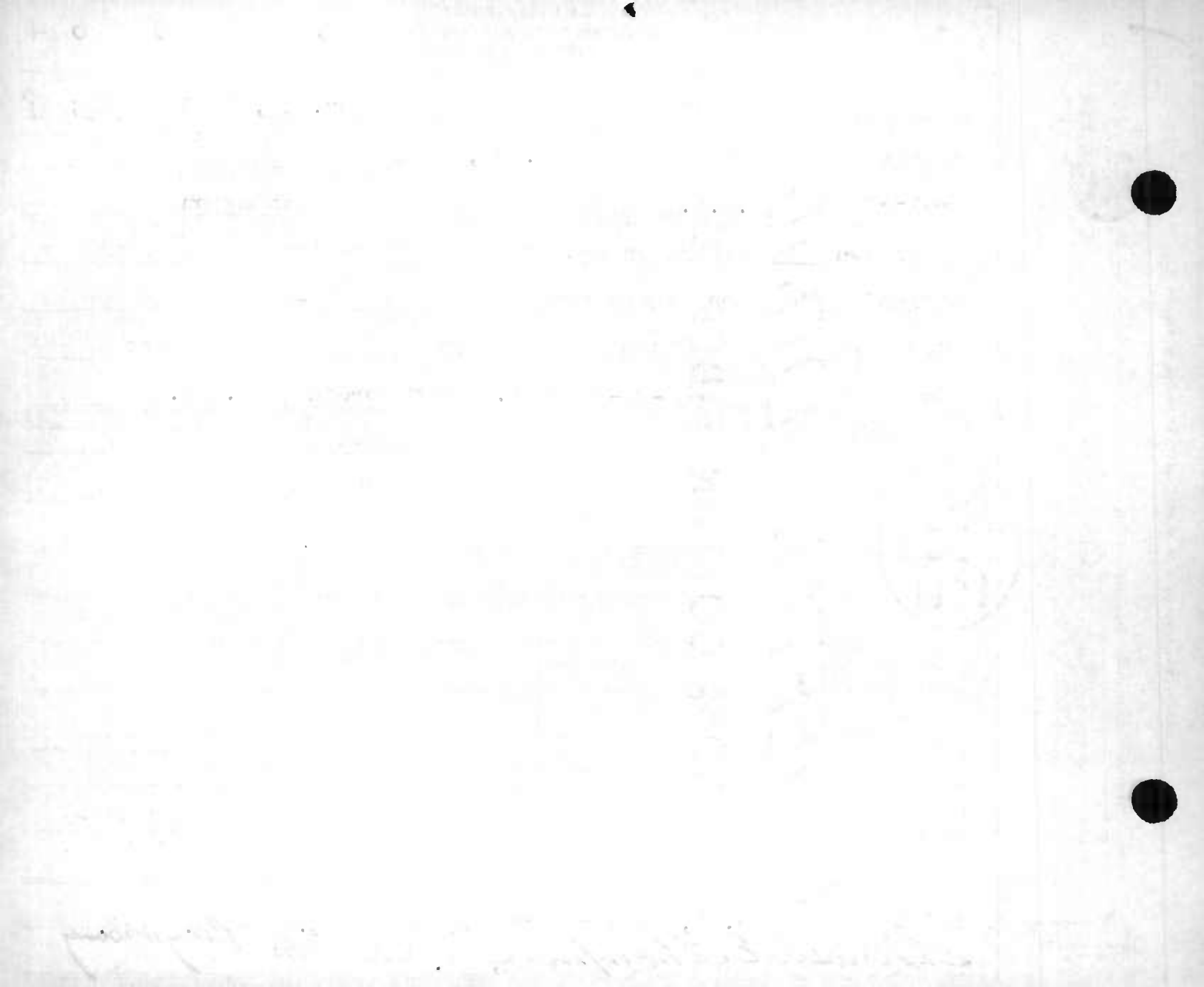
| | | | |
|--|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>James E. Thompson</i> | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 11-29-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Thompson | | 22e. ADDRESS | |

| | | | |
|--|-------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Dec. 2, 80 | 23c. NAME OF CEMETERY OR CREMATORY Broadfording | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington Md. |
| 24. FUNERAL DIRECTOR Name Donald E. Thompson | | 25a. DATE REC'D. BY REGISTRAR DEC 9 1980 | 25b. RECEIVED BY <i>Harry M. Barry</i> |
| 26. FUNERAL HOME Thompson Funeral Home | | 27. ADDRESS Cleonspring, Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 6 5 | | | |
|---|--|---|--|---|--|--|---|
| FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Gartanna A. Griffith | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 13, 1980 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 30, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 253 S. Mulberry St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Washington | | 13c. STREET ADDRESS 825 Lanvale St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gennaro - Starace | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margherita - Barrella | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 60 3857 | | 17. INFORMANT ADDRESS Mrs. Bessie Bovey Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 1552 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION 2/9/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Liver Biopsy | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12 , 19 79 , to 11/13 , 19 80 , that (I) (we) last saw the deceased alive on 7/23 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E Hoachlander MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/14/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E Hoachlander MD | | | | 22e. ADDRESS Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-15-80 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Maryland | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR NOV 20 1980 | | | |



[Faint, illegible handwritten text]

BP _____
DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND | | | | | | | | | | | | | |
|--|--|-------------------------------------|--|--|--|---|--|---|--|---|--|-----------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| REG. NO. 8029766 | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CARL NMN HARDY, III | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Nov. 24 1980 2b. HOUR 4:50 P.M. | | | | | | | |
| 3. SEX MALE | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1953 | | 6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR NOVEMBER 24 1980 2d. HOUR 4:50 M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Indiana | | 13b. COUNTY Cass | | 13c. CITY OR TOWN Logansport | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Route 5 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl Hardy, II | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>#E 816 - MOTOR VEHICLE ACCIDENT - LOSS OF CONTROL</u> DUE TO, OR AS A CONSEQUENCE OF <u>AND RUNNING OFF ROAD</u> (b) <u>CRUSHING CHEST INJURY, RESULTING IN MULTIPLE</u> DUE TO, OR AS A CONSEQUENCE OF <u>RIB FRACTURES; LACERATION LUNGS</u> (c) <u>BILATERALLY AND EXTENSIVE HEMOTHORAX</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS. 35 MIN. | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR AM/PM MONTH DAY YEAR 12:15 P.M. Nov. 24 1980 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) LOST CONTROL OF VEHICLE, RAN OFF ROAD, AND OVER SMALL EMBANKMENT | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) U.S. #30 | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5 MILE WEST HARRISONVILLE, FULTON, PENNA. | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto</u> | | | | TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER | | | | DATE SIGNED Nov. 25, 1980 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D. | | | | ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE Nov. 28, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Ever Rest Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Logansport, Indiana | | | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR NOV 28 1980 | | | | 25b. REGISTRAR'S SIGNATURE <u>John H. Brady</u> | | | | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | | | | |

301500

WATERHEAD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 80 29767 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR DATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JANET LOUISE HARNISH | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 9 80 | | | 2b. HOUR 1:15 A.M. | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH April 22, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Hagerstown | | 13c. STREET ADDRESS Route 6, Box 125, Cearfoss | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Lizzor, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie E. Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-3496 | | 17. INFORMANT ADDRESS Mr. Thomas F. Harnish, Hagerstown, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 79 to Nov 9 80 , that (I) (we) last saw the deceased alive on Nov 8 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Frederic A. Kross M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/9/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic A. Kross M.D. | | | | 22e. ADDRESS 1825 Howell Rd, Hagerstown Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 12, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park Hagerstown, Wash., Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Maryland 21740 | | | | 25a. DATE REG'D. BY REGISTRAR NOV 12 1980 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Robert McCreedy | | | |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY EDWARD HARTMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 20, 1980 | | 2b. HOUR 8:55 P M | | | |
| 3. SEX MALE | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR October 26, 1999 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) meat cutter | | 12b. KIND OF BUSINESS OR INDUSTRY Grocery Store | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Calvin B. Hartman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Metzger | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 214-09-9220 | | 17. INFORMANT ADDRESS Margaret C. Hartman, Hagerstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF AND (c) AND DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS | | | | | | | PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from Nov. 18 , 19 80 , to Nov. 20 , 19 80 , that (I) (X) lost saw the deceased alive on 11/20/ , 19 80 , and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <i>Edward W. Ditto</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Nov. 21, 1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D. | | | | 22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 24, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Fairfield Union Cem., Inc., Fairfield, Pa. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a. DATE RECEIVED BY REGISTRAR NOV 24 1980 | | 25b. REGISTERED BY <i>[Signature]</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 6 by be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 6 9 | | | |
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| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Anne Margery Harvey | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 21, 1980 | | 2b. HOUR 5:40 P. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Washington 13d. CITY OR TOWN Hagerstown 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13f. STREET ADDRESS 77 Manor Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Henry Bell, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes - LaRue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215 01 27990 | | 17. INFORMANT ADDRESS Mrs. Anne Jersey see # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of breast 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 4, 1980 , to Nov. 21, 1980 , that (I) (we) lost saw the deceased alive on Nov. 21, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Howard N. Weeks DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/24/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. | | | | 22e. ADDRESS 580 Northern Avenue Hagerstown, Maryland 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-24-80 | | 23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Ch. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hickory Maryland | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland ADDRESS 305 N. Potomac St. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 28 1980 | | 25b. RE Postmortem | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

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|--|--|---|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) Elizabeth Bledsoe Hattersley | | | 2a. DATE OF DEATH MONTH DAY YEAR November 15, 1980 | | 2b. HOUR M |
| 3 SEX Female | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 21, 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Washington | 13c. CITY OR TOWN Hagerstown | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Harrison Stickel | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Noma - Fuqua | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 225 50 8996 | | 17. INFORMANT ADDRESS Richard D. Hattersley, Sr. see # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5609 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable bowel obstruction</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Brain stem glioma</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 76 to 11/15, 19 80, that (1) (the) last saw the deceased alive on 11/14, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (did not) view the body after death. | | | | | |
| 22b. SIGNATURE George Newman II | | DEGREE Ph.D., M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Newman | | 22e. ADDRESS Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 11-16-80 | 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Maryland |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich | | 305 N. Potomac St. ADDRESS Hagerstown, Maryland | | 25a. DATE REC'D. BY REGISTRAR NOV 20 1980 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten signature or initials in the bottom left corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



| FOR 1. STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 7 1 REG. NO. | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Lucille Haugh | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 29 80 | | | | 2b. HOUR 9:25 A M | | | |
| 3. SEX Female | | 4. RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 6 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Williamsport | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 23 N. Vermont St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Artenis Milburn | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Adora Reid | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS J.A. Milburn Downsville Pike Hag., MD 21740 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal shutdown</u> <u>1579</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hyperosmolar hyperglycemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>30 hrs</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Carcinoma of Pancreas</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>9-25-80</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory laparotomy</u> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Jan 70</u> to <u>Nov 29 80</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>Nov 28 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>M.E. Byrkit</u> | | | | DEGREE <u>MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>Nov 29- 80</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M.E. Byrkit MD</u> | | | | 22e. ADDRESS <u>Williamsport Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>12-2-80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sharpsburg Washington MD</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Osborne Funeral Home P.O. Box 348 Wmspt., MD</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 5 1980</u> | | 25b. REGISTRAR'S SIGNATURE <u>Ricky McBrady</u> | | | |

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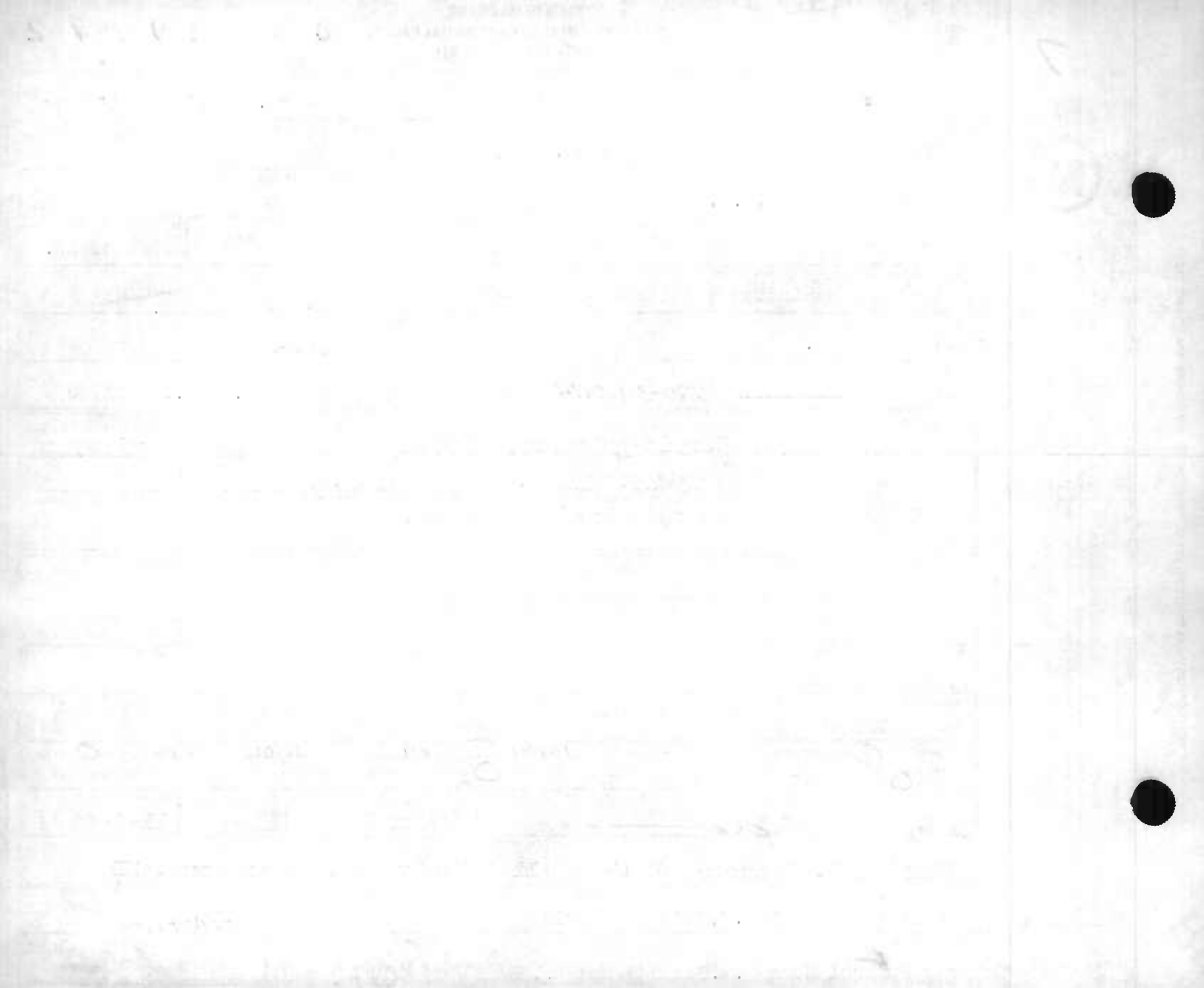


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 7 2 | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | | 2a DATE OF DEATH | | | | REG. NO. | | | |
| Ellen Heffner | | | | Nov. 1, 1980 | | | | 530 P.M. | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | |
| female | | white | | Jan. 21, 1902 | | 78 | | Pennsylvania | | U.S.A. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Hagerstown | | Washington County Hospital | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Washington | | | | | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | 13a INSIDE CITY LIMITS? | | 13b STREET ADDRESS | | | | | |
| Teacher | | Board of Ed. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 125 N. Antietam St. | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | |
| Bruce E. Nevin | | Mary UNK Grier | | no | | 220-34-0174 | | Eugene Flurie | | 849 Kenly Ave. Hag., MD 21740 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary arrest | | | | | | | | | | minutes | |
| 4370 } DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis with severe chronic brain syndrome. | | | | | | | | | | one year | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 12/09, 1964, to 11/01, 1980, that (I) (we) last saw the deceased alive on 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c DATE SIGNED | |
| 22b SIGNATURE | | | | | | | | | | 11-3-80 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e ADDRESS | |
| Charles C. Spencer, M.D. | | | | | | | | | | 1198 Kenly Ave. Hagerstown, MD | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| burial | | Nov. 4, 1980 | | Fairview Cemetery | | Mercersburg | | FRANKLIN | | PA | |
| 24 FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Osborne Funeral Home P.O. Box 348 Wmsnt., MD | | | | | | | | NOV 10 1980 | | P. J. H. H. H. | |



TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 0 2 9 7 7 3 | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) John Stanley HUFF | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 3, 1980 | | | | 2b. HOUR 11 ³⁰ AM | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR July 23, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) blacksmith | | 12b. KIND OF BUSINESS OR INDUSTRY railroad | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Nelson Huff | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Marshall | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 705-10-4703 | | 17 INFORMANT ADDRESS Jennie L. Huff, Hagerstown, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 6 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>September</u> , 19 <u>79</u> , to <u>Nov. 03</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>Nov. 03</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Charles C. Spencer</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11/04/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles C. Spencer, M.D. | | | | 22e. ADDRESS 1198 Kenly Ave. Hagerstown, MD. 21740 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 6, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | |
| 24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME | | | | 24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | 25a. DATE REC'D. BY REGISTRAR NOV 7 1980 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Robert M. [unclear]</i> | | | | | |

1894

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 17, 1894

ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS
1894

1894

DMMH - 17
(VR A15 ME (5))
15M/7/77

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 29774 | |
|---|--|----------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Lancaster ITNYRE | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR Nov. 18, 1980 | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1910 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 70 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2b. HOUR 2:30 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD Nov. 18, 1980 | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed | | 12b. KIND OF BUSINESS Radio & T.V. Repair | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 131 Ray Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Itnyre | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Gross | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-09-9851 | | 17. INFORMANT ADDRESS Roy W. Rafter, 3 Dale Dr., Annapolis, Md. 21403 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Code 038) Septicemia and renal failure DUE TO, OR AS A CONSEQUENCE OF (Code 586) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/24/80 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Decubiti on ischium (Paraplegic) | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Howard N. Weeks</i> | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | DATE SIGNED 11/18/80 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. | | | | ADDRESS 580 Northern Avenue Hagerstown, Maryland 21740 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE Nov. 20, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 24 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Robert J. [Signature]</i> | | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | | |



0821 8 1019

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 29775 | | | | | | | | | | | |
|--|--|---------|--|------------------|---|--|-------------------|--|----------------|--|------------------|--|--------------------------|--|--------------------------------------|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | 2a. DATE KNOWN OF DEATH | | | | | MONTH DAY YEAR HOUR | | | | | | | | | | | | | | | | |
| David Franklin KENDLE | | | | | | | | | | November 17 1980 | | | | | 12:35 P.M. | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | | MONTH DAY YEAR HOUR | | | | | | | | | | | | | |
| male | | white | | Oct. 17, 1935 | | | 45 YRS. | | MONTHS DAYS | | HOURS MIN. | | Nov. 17 1980 | | | | | 12:35 P.M. | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | MD. | | | | | | | | | | | |
| Pennsylvania | | | | | USA | | | | | | | | | | Washington | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | |
| Hagerstown | | | | | Washington County Hospital | | | | | foreman | | | | | Air Cond. & Heating | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | |
| 13a. STATE 13b. COUNTY | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | Route 4, Box 283 | | | | | | | | | | | |
| Maryland Washington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | | |
| Albert E. Kendle | | | | | | | | | | Mary P. Kuhn | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| | | | | | | | | | | 217-32-6769 | | | | | | | | | | Mrs. Yvonne E. Snyder Kendle, Hag., Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (d) (Code N803) Basal skull fracture | | | | | | | | | | | | | | | | | | sudden | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Fall from ladder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Electrocution (Code E881) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 10:30 Nov. 17, 80 | | | | | | | | | | Electrocuted and fell from ladder | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | | |
| | | | | | | | | | | Home of relative | | | | | | | | | | Route 4 Cearfoss Wash. Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | |
| Howard N. Weeks, M.D. | | | | | | | | | | Deputy | | | | | | | | | | 11/18/80 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| Howard N. Weeks, M.D. | | | | | | | | | | 580 Northern Aven. Hagerstown, Maryland 21740 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | |
| burial | | | | | | | | | | Nov. 20, 1980 | | | | | | | | | | Cedar Lawn Mem. Prk | | | | | | | | | | Hagerstown, Wash., Maryland | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | 25. DATE OF BURIAL BY REGISTRAR | | | | | | | | | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| MINNICH FUNERAL HOME | | | | | | | | | | NOV 21 1980 | | | | | | | | | | | | | | | | | | | | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



1971 12 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 0 2 9 7 7 6 | | | |
|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eleanor Esther Knepper | | | | 2b. MONTH DAY YEAR 11 17 80 | | | |
| 3. SEX Female | | | | 4. RACE white | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR 2 5 09 | | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Center | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE md. | | | | 13b. COUNTY Wash. | | | |
| 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 1021 Spruce St. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Bauman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie L. Werking | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 218-38-1607 | | | |
| 17. INFORMANT ADDRESS Mr. Wm. E. Knepper, Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis with residual stroke</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonitis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Howard N. Weeks</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/17/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. | | | | 22e. ADDRESS 580 Northern Avenue Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 19, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | |
| 24. FUNERAL DIRECTOR NAME The Minnich Funeral Home | | | | ADDRESS Hagerstown, Md. 21740 | | 25. DATE REC'D. BY REGISTRAR NOV 21 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i> | | | |

BP



0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80

29777

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | |
| -Frank Joseph Kronawetter Jr. | | | Male | | | White | | | MONTH DAY YEAR 6 26 09 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| PENNSYLVANIA | | | U.S.A. | | | | | | Washington County MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | 1336 Salem Avenue | | | | | | Railroad | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| MD. | | | Wash. | | | Hagerstown | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | |
| Frank J. Kronawetter, Sr. | | | Marie | | | No | | | 705-10-4936 | | |
| 17. INFORMANT | | | ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease and</u> Cor pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> | | |
| Mrs. Thelma Kronawetter, Hagerstown, Md. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | |
| Severe chronic obstructive pulmonary disease, acute duration | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>7-6</u> , 19 <u>64</u> , to <u>11-20</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11-12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (we) view the body after death. | | | 22b. SIGNATURE <u>Charles C. Spencer</u> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | |
| Charles C. Spencer, M.D. | | | 1198 Kenly Ave. Hagerstown, MD. 21740 | | | burial | | | Nov. 22, 1980 | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | |
| Rest Haven Cemetery | | | Hagerstown, Wash., Maryland | | | MINNICH FUNERAL HOME | | | NOV 24 1980 | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Robert H. H. H.</u> | | |

BP



W. W. F. W. A.



BP

DHMH - 17
(VR A15 ME (5))
15M 7/771- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|-------------------------|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Lloyd Edgar LEATHER | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11-15 1980 | | 2b. HOUR 2:30 a.m. |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1919 | 6. AGE (IN YEARS) LAST BIRTHDAY 60 | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. YRS. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11-15 1980 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Williamsport | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lewis Leather | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Berti Elizabeth Irving | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. W.W. II 213-18-8982 | | 17. INFORMANT ADDRESS Mrs. Betty A. Leather, Williamsport, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Code 429 (Arteriosclerotic cardiovascular sudden disease) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Howard N. Weeks</i> | | TITLE (SPECIFY) Deputy | | DATE SIGNED 11/17/80 | |
| EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. | | ADDRESS 580 Northern Ave., Hagerstown | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov 18, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 | | 25a. DATE REC'D. BY REGISTRAR NOV 21 1980 | | 25b. REGISTRAR'S SIGNATURE <i>Robert H. Brady</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



APR 11 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

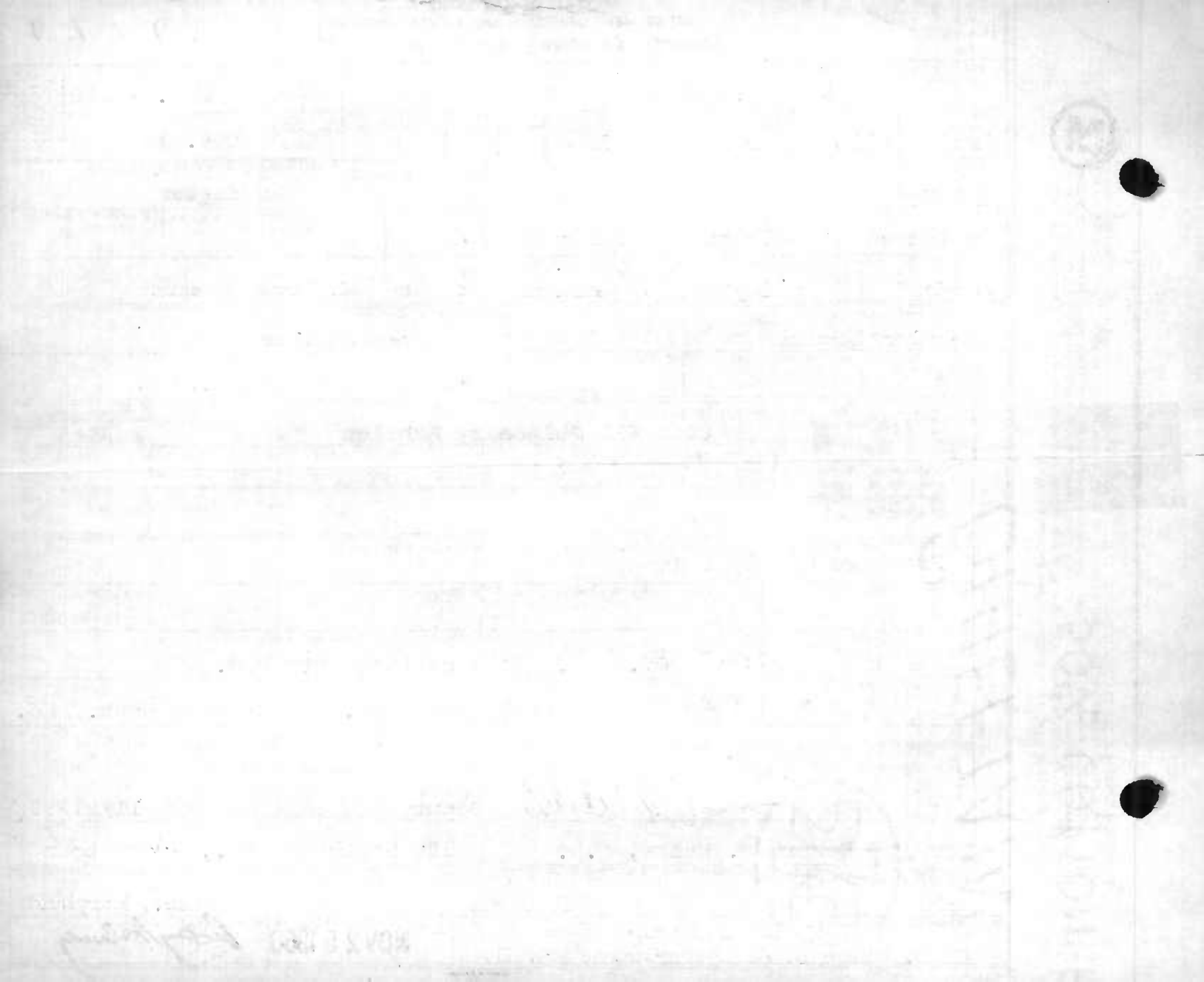
DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|------------------|---|--|------------------|--|--|---|---|-----------------------------|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| Elsie Stouffer LEHMAN | | | | | | NOV. 19 80 | | | 12:25 P M | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | | | | |
| female | white | Mar. 30, 1887 | 93 | | | NOV. 19 80 | | | 12:25 P M | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD | | | | | |
| Maryland | | | USA | | | | | | Washington | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Hagerstown | | | Washington County Hospital | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | Washington | | | Hagerstown | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 847 Dewey Avenue | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| Abraham Lehman | | | | | | Emma Stouffer | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | |
| No | | | | | | Helen Green, Hagerstown, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | sudden | | | | | |
| IMMEDIATE CAUSE (a) Code 415 Pulmonary Embolus | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| Fracture of Right Hip | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | 7:00 P.M. NOV. 4 19 80 | | | | Fell getting into bed. | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, PARK, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| | | | | Home | | | | 847 Dewey Ave. Hagerstown Wash. Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | |
| <i>Howard N. Weeks</i> | | | | M.D. Deputy | | | | MEDICAL EXAMINER | | | | 11/21/80 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Howard N. Weeks, M.D. | | | | 580 Northern Ave., Hagerstown | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| burial | | | | Nov. 22, 1980 | | Rose Hill Cemetery | | | | Hagerstown, Wash., Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| MINNICH FUNERAL HOME | | | | NOV 25 1980 | | | | <i>Howard N. Weeks</i> | | | | | | | | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|-------------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 80 29780 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR M | |
| Roy Allen | | Leiter Sr. | | November | | 9, 1980 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| male | | white | | October 1, 1879 | | 101 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | | | |
| Maryland | | U.S.A. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | 1715 Fountainhead Rd. | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS | | | | | |
| Md. | | Washington | | Hagerstown | | 1715 Fountainhead Rd. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Lewi Frederick | | Leiter | | Sarah Mentzer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 217-18-7674A | | Roy Allen Leiter, Jr., Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prostatic Hypertrophy</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 to <u>Nov 9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Nov 2</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Charles A. Hoffmann</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>11/10/80</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lloyd A. Hoffmann</u> | | 22e. ADDRESS <u>1147 Oak Hill Ave.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | Nov. 12, 1980 | | Rose Hill Cemetery | | Hagerstown, Wash. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | NOV 13 1980 | | <u>Robert McCreedy</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 2 9 7 8 1 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | | | |
| (TYPE OR PRINT) Paul Edward Lizer | | | | Nov. 11, 1980 | | | |
| 3. SEX | | | | 2b. HOUR | | | |
| Male | | | | 5:17 P.M. | | | |
| 4. RACE | | | | 5. DATE OF BIRTH | | | |
| White | | | | Nov. 1, 1906 | | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7. AGE (IN YEARS LAST BIRTHDAY) | | | |
| Maryland | | | | 74 YRS. | | | |
| 8. CITIZEN OF WHAT COUNTRY? | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| USA | | | | Washington MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | |
| Hagerstown | | | | 315 N. Mulberry St. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| meat jobber | | | | wholesale | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | |
| Maryland | | | | Washington Hagerstown | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| John Edward Jones | | | | Eva Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| no | | | | | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Corinne Lizer | | | | see # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of Lung | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cigarette Smoking | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Heart Disease - Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | | | | |
| 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | |
| | | | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| | | | | 21f. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | 9th 65 to 11/11 19 80 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/18 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| DONALD E. MARTIN MD | | | | 11-13-80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| DONALD E. MARTIN MD | | | | 363 S. Cleveland Ave Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | |
| Burial | | | | 11-14-80 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Rose Hill Cemetery | | | | CITY OR TOWN COUNTY STATE | | | |
| Hagerstown, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| NAME Gerald N. Minnich | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| ADDRESS 305 N. Potomac St. Hagerstown, Maryland | | | | NOV 20 1980 | | | |



[Faint, illegible handwritten text covering the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 8 2 | | | |
|---|--|---|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Lena (NMN) Loewer | | | 2a. DATE OF DEATH MONTH DAY YEAR November 21, 1980 | | | 2b. HOUR 2:50p.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 12, 1882 | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD. | |
| 10. CITY OR TOWN OF DEATH Williamsport | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Theodor Burmann | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Braun | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- -- 217-48-5918 | | 17. INFORMANT Myrtle A. English | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary edema 4140 conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) acute congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours hours years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug 78, to 21 Nov 80, that (I) (we) lost saw the deceased alive on 21 Nov 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Harold R. Tritch | | DEGREE MD. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 22 Nov 1980 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. Tritch Jr. M.D. | | | | 22e. ADDRESS 138 E. Antietam St., Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 11-22-80 | | 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium | | 23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Washington, Md. | |
| 24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 25 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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(VRA 15, 4) 7/78

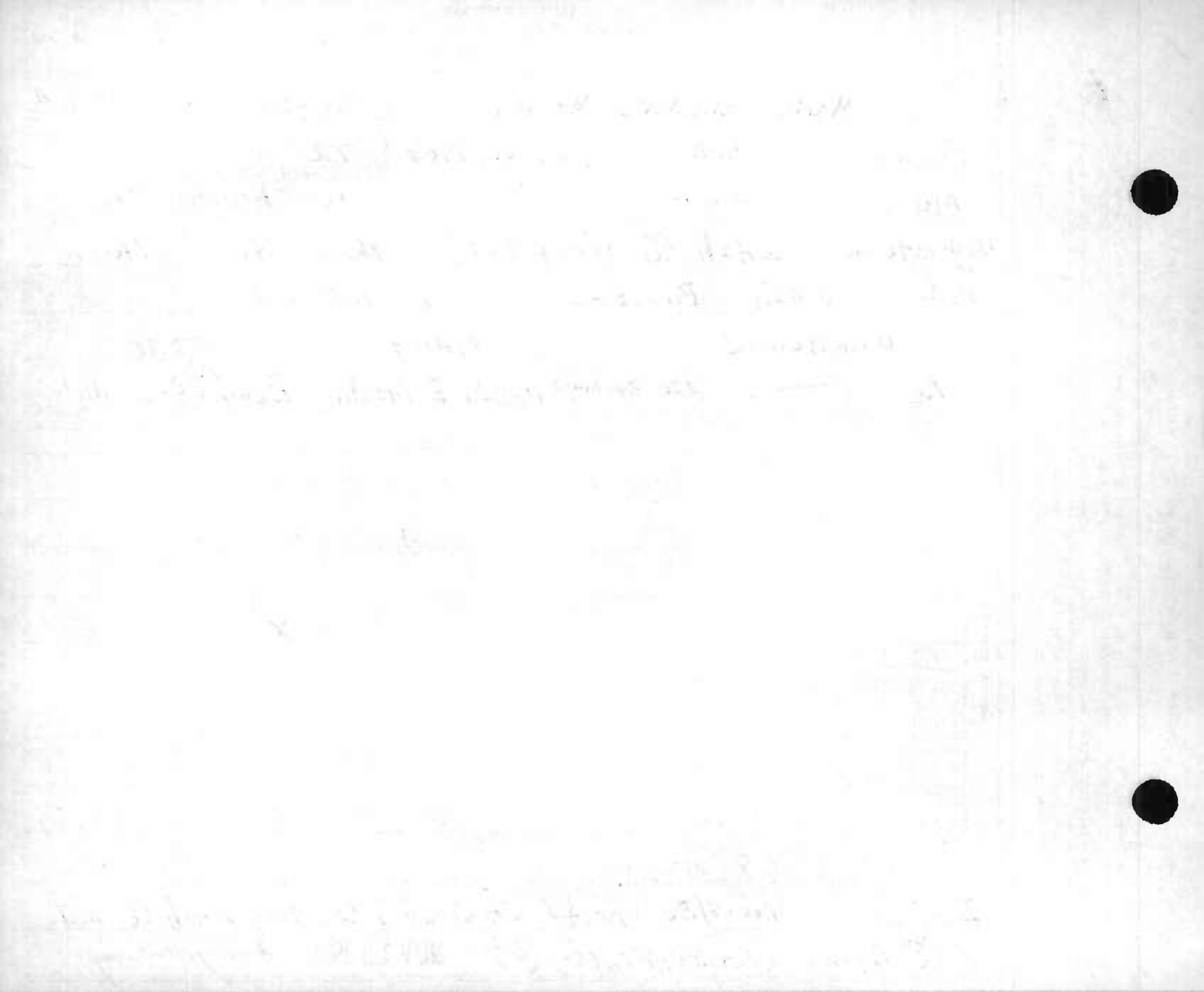


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 2 9 7 8 3 | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Marie Elizabeth Martin | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 11, 1980 | | | | 2b. HOUR DAY YEAR 8:30 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 20, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 72 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 72 | | 8. IF UNDER 24 HRS. HOURS MIN. 72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. Co. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. STATE MD. | | 13b. COUNTY WASH. | | 13c. CITY OR TOWN Boonsboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS R.D. #2 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY STRITE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-0043 | | 17. INFORMANT ADDRESS R.D. #2 Mervin B. Martin - Boonsboro, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) probable myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) an massive pulmonary embolus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/11/80 to 11/11/80 , that (I) (we) lost saw the deceased alive on 11/11/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11/11/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] | | | | 22e. ADDRESS 1825 Howell Road Hager MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Nov. 14/80 | | 23c. NAME OF CEMETERY OR CREMATORY Reiff Ch. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Centers Wash. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME A.E. Munnich ADDRESS Greencastle, Pa. | | | | 25. DATE REC'D BY REGISTRAR NOV 13 1980 | | | | REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 2 9 7 8 4 | | | |
|--|--|---|--|---|--|---|--|--------------------|--|--|-----|-------|---------|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH | DAY | YEAR | 2b HOUR |
| Ruth | | M. | | Martin | | November 22, 1980 | | 10:08 ^P | | | | M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | 18/9/1922 | | 58 | | MONTHS | | DAYS | | HOURS | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Penna. | | U.S.A. | | | | Washington Co. | | | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Hagerstown | | Washington Co Hospital | | Stanley Co | | Machine | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | | |
| Penna. | | Franklin | | Greencastle | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | R.D.# 4 | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Edgar | | Landis | | Emma | | Grace | | Kriner | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | | | | |
| no | | 159-19-5924 180-19-5924 | | J. Earl Martin | | R.D.# 4 Greencastle, Pa. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8-2</u> , 19 <u>76</u> , to <u>11-22</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10-14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b SIGNATURE <u>John Hornbaker Jr</u> | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <u>11-24-80</u> | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | |
| Dr John Hornbaker Jr | | 645 East First St. Hagerstown, Md | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 11/25/1980 | | Shanks Church Cem | | Antrim Twp Franklin Penna | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| <u>Arnold M. Zimmerman</u> | | <u>Greencastle, Pa</u> | | NOV 28 1980 | | <u>History McCreedy</u> | | | | | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 7 8 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Thomas Howell McElROY | | | 2a. DATE OF DEATH MONTH DAY YEAR November 11, 1980 | | 2b. HOUR M |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR July 26, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) foundry | | 12b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp. |
| 13a. STATE Maryland | | | 13b. COUNTY Washington | 13c. CITY OR TOWN Hagerstown | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS 220 W. First Street | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Jane McCoy | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Thomas McElroy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Jane McCoy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-0500 | | 17. INFORMANT ADDRESS Mrs. Devona McElroy, Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Obtained Libellatus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 1972 to Nov. 1980, that (I) (we) last saw the deceased alive on Nov. 10, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 21b. SIGNATURE Gloria F. Pura MD. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/11/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PURA | | 22e. ADDRESS 382 S. CLEVELAND HAGERSTOWN | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 13, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | 25a. DATE REC'D. BY REGISTRAR NOV 17 1980 | | | |

35 211 1
MEDICAL CERTIFICATION
9 9 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

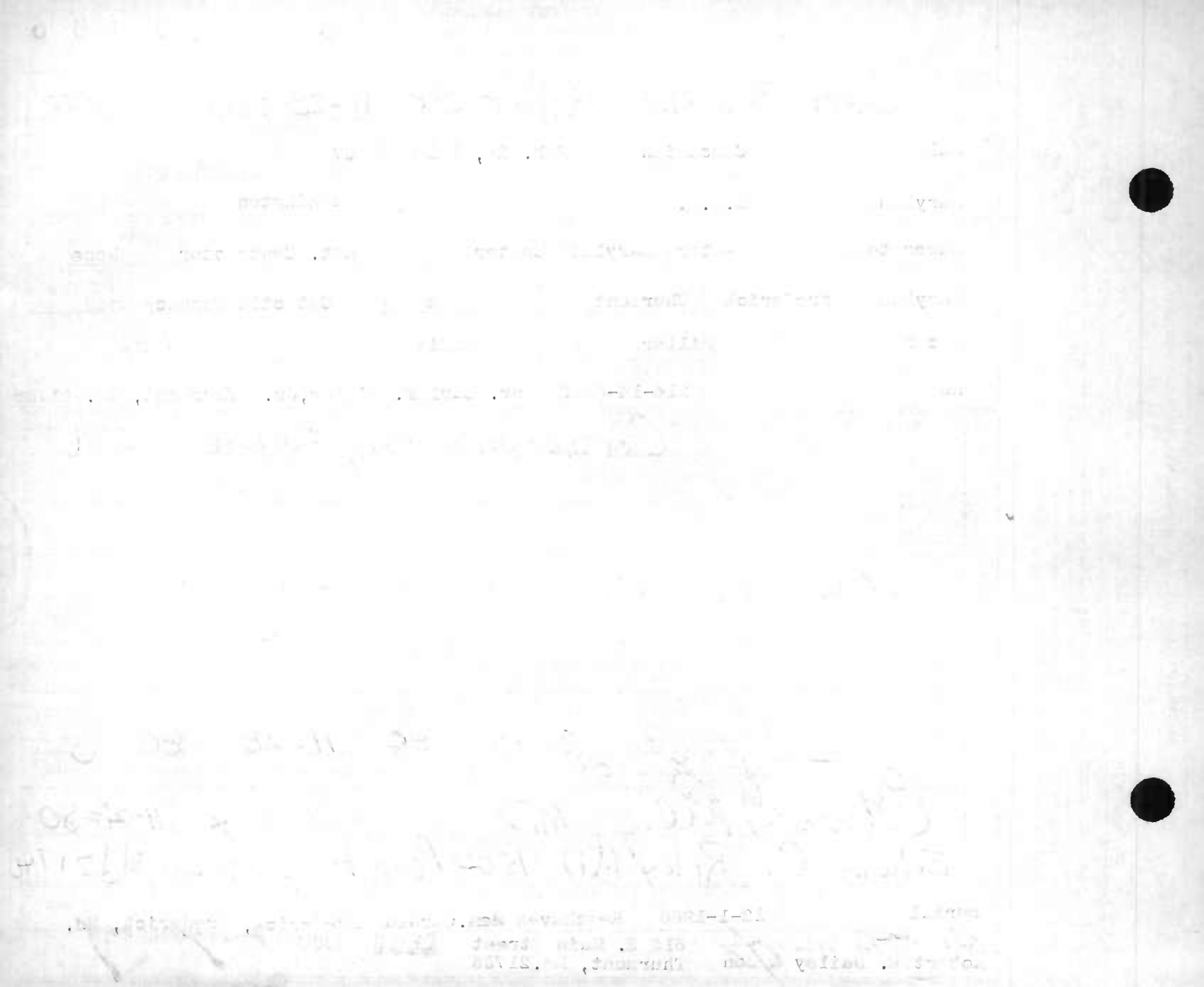
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 29786

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Carl Franklin Miller, Sr | | 2a. DATE OF DEATH MONTH DAY YEAR 11-28-1980 | | 2b. HOUR 3:30 P M | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1913 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | | 8. IF UNDER 24 HRS HOURS MIN. YRS. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Contractor | |
| 12b. KIND OF BUSINESS OR INDUSTRY None | | 13a. STREET ADDRESS Catoctin Furnace Road | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13c. CITY OR TOWN Thurmont | | 13d. STATE Maryland | | 13e. COUNTY Frederick | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Miller | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Weddle | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 214-14-6912 | | 17. INFORMANT Mr. Carl F. Miller, Jr. | | ADDRESS Thurmont, Md. 21788 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4289 Cardio-pulmonary failure IMMEDIATE CAUSE (a) Cardio-pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) 2d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic, cachectic, mental retardation | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic, cachectic, mental retardation | | | | | |
| 19a. DATE OF OPERATION 9-18-80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic, cachectic, mental retardation | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11-28-80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1500 Penn Hagerstown, Md 21740 | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 9-18-80 to 11-28-80 , that (I) (we) last saw the deceased alive on 11-28-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Edwin G. Riley MD | | 22c. DATE SIGNED 11-28-80 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin G. Riley MD | |
| 22e. ADDRESS 1500 Penn Hagerstown, Md 21740 | | 23a. BURIAL, CREMATION, REMOVAL Burial | | | |
| 23b. DATE 12-1-1980 | | 23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Robert E. Dailey & Son 615 E. Main Street Thurmont, Md. 21788 | | 25. DATE OF DEATH DEC 3 1980 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 80 29787 | | | |
|---|--|---|--|--|--|---|--|---------------------|--|---|-----|-----------|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| George Lafayette | | MILLER | | | | | | Nov. 6, 1980 | | | | | M |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| male | | white | | June 7, 1991 | | 89 | | MONTHS | | DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | MD. | |
| Maryland | | USA | | | | Washington | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Hagerstown | | 9 S. Burhans Blvd. | | stone mason | | construc. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | Wash. | | Hagerstown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9 S. Burhans Blvd. | | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | |
| Joseph | | Miller | | | | Rebecca | | | | | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | | | | |
| no | | 220-18-3072 | | Ruth M. Skelton | | Hagerstown, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>4439</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe peripheral vascular disease -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral vascular disease -</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>10/20/80</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE <u>L. Dwight Wooster</u> DEGREE | | 22c. DATE SIGNED <u>11/7/80</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| L. Dwight Wooster | | 1825 Howell Rd. Hagerstown, MD. 21740 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| cremation | | 11-7-80 | | Smithsburg Crematory | | Smithsburg, Md. | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. | | NOV 13 1980 | | <u>History McCreedy</u> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 2 9 7 8 8 | |
|--|--|--|---|---|------------------------------------|--|---|---|------------------|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR P M | | |
| Mary Ellen Miller | | | | | | November 20, 1980 | | | 10:40 M | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS HOURS MIN | |
| Female | | White | | Dec. 31, 1928 | | 51 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | | USA | | | | Washington County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Western Maryland Hospital Center | | | | Maintenance | | Manbeck Bread | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| W. Va. | | | Berkley Co. | | | Martinsburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt. 3, Box 122AA | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| John R. Nave | | | Elsie May Weaver | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | | 17 INFORMANT ADDRESS | | | | | |
| no | | | 213 24 8512 | | | Diana L. McGowan RT.3 Box 122AA W.VA | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1619 } DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of the larynx and hypopharynx | | | | | | | | | | 11/19/80 | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | Oct. 1979 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) mellitus Post total laryngectomy, pharyngectomy with radical neck dissection. Diabetes/ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 30, 1980, to Nov. 20, 1980, that (I) <input checked="" type="checkbox"/> saw the deceased alive on Nov. 20, 1980, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| Fe U. Porciuncula | | | M.D. | | | | | | NOV 21, 1980 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Fe U. Porciuncula, M.D. | | | Western Maryland Hospital Center | | | 1500 Pennsylvania Ave., Hagerstown, Md. 21740 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | | Nov. 25, 1980 | | Cedar Lawn Mem. Park | | Hagerstown Washington MD | | | | |
| 24 FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE OF DEATH BY TELETYPE OR SIGNATURE | | | | | |
| Osborne Funeral Home | | | P.O. Box 348 Wmspt., MD | | | NOV 28 1980 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | 8 0 2 9 7 8 9 | | | | | | |
|--|--|---|--|---|--|--|---|--|-------------------------------------|-----------------|------|--------------------|
| 1. FOR STATE REGISTRAR | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR |
| Arletta Geneva MOATS | | | | | | November 23, 1980 | | | | | | 8:00 ^{MA} |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | | White | | April 11, 1920 | | 60 | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Boonsboro, Md. | | U. S. A. | | | | Washington | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Fairplay | | Rfd. 1 Box 9 | | | | Housewife | | Own Home | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | | Washington | | Fairplay | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rfd. 1 Box 9 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Ernest H. Leggett | | | Gertie V. Baker | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| No | | | 220-16-3993 | | Mr. Conrad E. Moats, Rfd. 1 Box 9, Fairplay, Md. 21733 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART I. DEATH CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Adenocarcinoma with hepatic metastasis</u> | | | | | | | | | | | | |
| 1991 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary site unknown</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-3</u> , 19 <u>79</u> to <u>11-23</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Eric M. Wagshal</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>11-24-80</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal, M.D. | | | 22e. ADDRESS 1825 Howell Road Hagerstown, MD. 21740 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | | | | |
| Burial | | | 11-26-80 | | Manor Cemetery | | Tilghmanton, Wash. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713 | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 26 1980 | | 25b. REGISTRAR'S SIGNATURE <u>H. H. H. H. H.</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8029790 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth Moser | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 3, 1980 | | 2b. HOUR 8:00 P _M | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR March 2, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Weddle | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie J. | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO 217-10-2541 | | 17. INFORMANT ADDRESS Charles W. Moser, Sr., Route 1, Box 387 Boonsboro, Md. | | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dr. Weeks for Dr. Datta</u> , 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Howard N. Weeks</i> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/4/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. | | | | 22e. ADDRESS 580 Northern Avenue Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 6, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE Myersville, Wash., Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MENNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a. DATE REC'D BY REGISTRAR NOV 7 1980 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 80 29791 | | | |
|--|---------------------|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Arthur Edward Myers | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 25 80 | | 2b. HOUR 9 34 AM | |
| 3 SEX male | 4 RACE C. | 5. DATE OF BIRTH MONTH DAY YEAR 10 19 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS 11 25 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. BALTIMORE CITY OR COUNTY OF DEATH Washington MD | | 11. UNDER 24 HRS HOURS MIN. 9 34 | |
| 12. CITY OR TOWN OF DEATH Hagerstown | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon manor | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Delivery | | 15. KIND OF BUSINESS OR INDUSTRY Wholesale | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hancock | | | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS 70 E. Main Street | |
| 19. FATHER'S NAME FIRST MIDDLE LAST Levi B. Myers | | | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mae Souders | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 22. SOCIAL SECURITY NO. 705 10 7941 | | 23. INFORMANT ADDRESS Ruth I. Myers 281 1/2 W. Main St. Hancock, Md. | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) arteriosclerotic heart disease (c) due to, or as a consequence of | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Alcohol consumption | | | | | | | |
| 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 10 71 | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 71 | | | |
| 32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1-10 | | 34. LOCATION STREET CITY OR TOWN COUNTY STATE 71 10 19 80 | | 35. I certify that (I) (this hospital) attended the deceased from 1-10 71 to 10-19-80 , that (I) (we) lost saw the deceased alive on 10-19-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | |
| 36. SIGNATURE E. R. Landis | | 37. DEGREE MD | | 38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 39. DATE SIGNED 11-25-80 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) E. R. Landis | | 41. ADDRESS 382 South Alameda, Hagerstown, Md. | | 42. DATE REC'D. BY REGISTRAR DEC 3 1980 | | | |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 44. DATE 11-28-80 | | 45. NAME OF CEMETERY OR CREMATORY Tonoloway Baptist | | 46. LOCATION CITY OR TOWN COUNTY STATE Fulton Co., Penna | |
| 47. FUNERAL DIRECTOR NAME ADDRESS Richard D. Lane Hancock MD. | | | | 48. DATE REC'D. BY REGISTRAR DEC 3 1980 | | | |

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Chapman, W. H.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 0 2 9 7 9 2 | |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Charles Robert Nace | | 11-30-1980 | | 7:40 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | July 9, 1915 | 65 YRS. | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Ohio | U.S.A. | | Washington MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | Washington County | Foreman | Steel | | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | |
| Maryland | Washington | Hagerstown | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 193 Lakeside Court | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| John Nace | | Emma | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| Yes | | WW-2 | Mrs. Irene Nace Hagerstown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) | | | | | |
| 4920 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-78 to 1978, that (I) (we) last saw the deceased alive on 11-29-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Ward | | MD | | 11-30-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Ed. Landis | | 382 Highwood Ave, Hagerstown Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | Nov. 30, 80 | | Smithsburg | |
| 23d. LOCATION | | 23e. CITY OR TOWN | | 23f. COUNTY | |
| Smithsburg | | Wash. Md. | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE OF DEATH | | 26. REGISTRAR | |
| Donald E. Thompson | | DEC 4 1980 | | | |
| Thompson Funeral Home | | Clearspring Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8029793 | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anna Veleda PAXSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 25, 1980 | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George E. Snyder | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Miller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-74-2722 | | 17. INFORMANT ADDRESS Helen Brunngraber, Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Stomach</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Accid.</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>Nov 20</u> 19 <u>80</u> to <u>Nov 25</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE <u>Robert Brull</u> | | 22c. DATE SIGNED 11/25/80 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull, M.D. | | | |
| 22e. ADDRESS 1198 Kenly Ave., Hagerstown, MD. 21740 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 28, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash., Maryland | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 28 1980 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 80 29794 | | | |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Elizabeth H. Pentz | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-25-80 | | | |
| 2b. HOUR 330 AM | | | | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Oct 6 1912 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Food Industry | |
| 13a. STATE Penn. | | 13b. COUNTY Franklin | | 13c. CITY OR TOWN State Line | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS Box 88 | | 14 FATHER'S NAME FIRST MIDDLE LAST John Henry Hauscholder | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Weaver | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 189-44-4310 | | 17 INFORMANT Mr. Betty Hill, Baltimore, Md | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-29, 1971 , to 11-25, 1980 , that (I) (we) last saw the deceased alive on 11-24, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John Hornbaker Jr. | | | | DEGREE MD | | 22c. DATE SIGNED 11-25-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Hornbaker Jr. | | | | 22e. ADDRESS Hagerstown, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/28/1980 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Antietam Twp Franklin Penna | |
| 24 FUNERAL DIRECTOR NAME Harold L. Zimmerman | | | | 25a. DATE RECEIVED BY REGISTRAR DEC 8 1980 | | | |
| ADDRESS Greenbelt, Md | | | | 25b. REGISTRATION NO. 1580 | | | |

NOV 2 1905



Handwritten notes at the bottom left corner, possibly a signature or date.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 0 2 9 7 9 5 | |
|--|--|----------------------------------|--|---|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katherine Louise REEDY | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR NOV 27 19 80 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 25, 1936 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 44 RS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR NOV 27 19 80 | | 2b. HOUR 7:20 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shepherdstown, W. Va. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1053C Nolan Dr. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Miller | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Mae Miller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 213-40-4956 | | 17. INFORMANT ADDRESS Mr. David A. Miller, Rfd. 2 Box 139 Williamsport, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) - Aspiration of gastric Contents DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Al-933 DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NOV 27 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Volunt - Aspiration of gastric Contents | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Noland Village Hagerstown Md Wash | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Dicks | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED NOV 28, 1980 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dicks MD | | | | ADDRESS 27 W. Wash. St. Hagerstown Md 21740 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12- 1- 80 | | 23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Samples Manor Wash Co. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713 | | | | | | 25a. DATE OF REGISTRATION DEC 3 1980 | | 25b. REGISTRAR'S SIGNATURE | | | |

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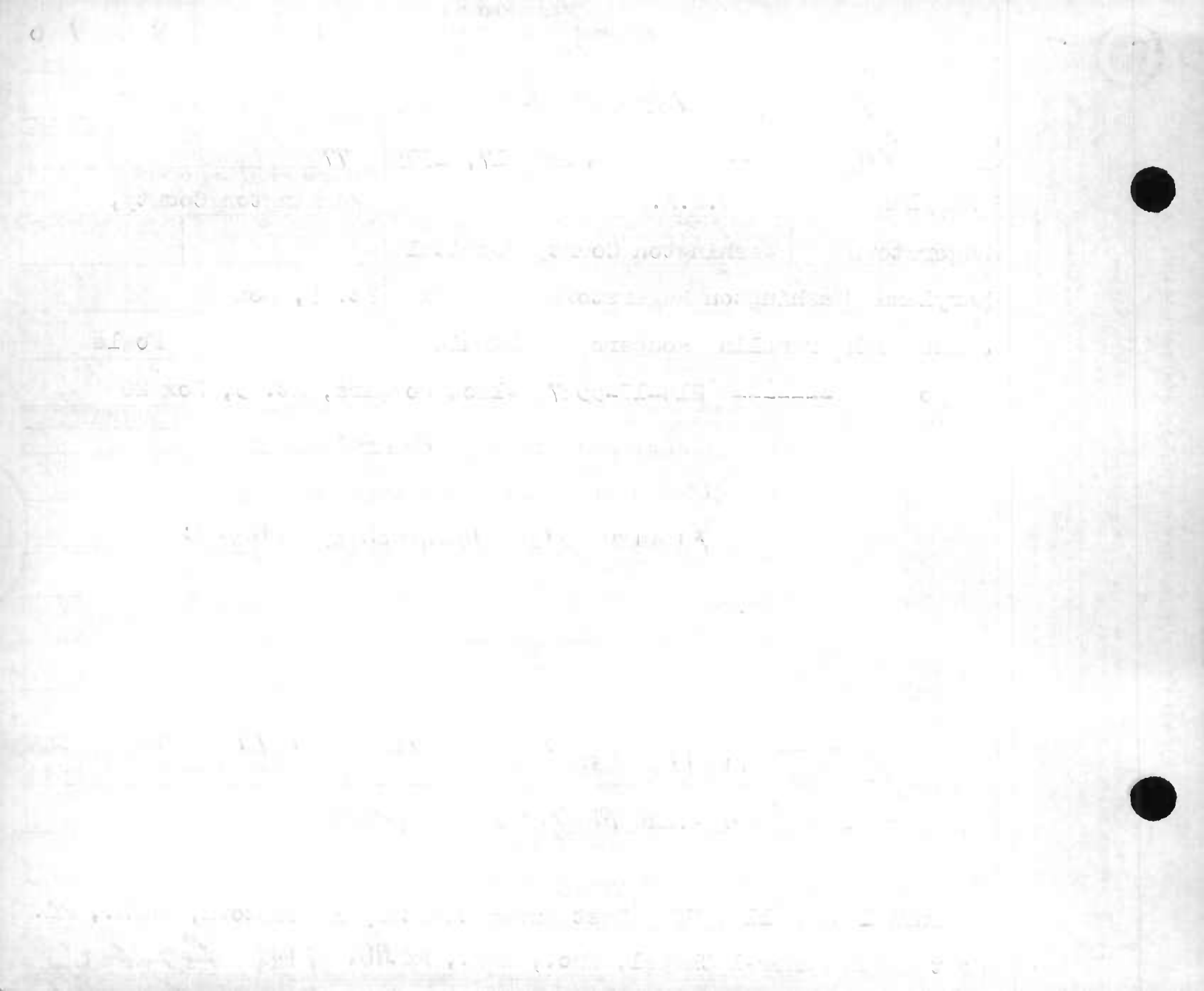
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 9 6 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) James Albert Rodgers | | | | 2a. DATE OF DEATH MONTH DAY YEAR 11-1-80 | | 2b. HOUR M | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR June 17, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, Md. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 5, Box 20 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Noah Franklin Rodgers | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Fogle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-10-5527 | | 17. INFORMANT ADDRESS Alice Rodgers, Rt. 5, Box 20 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 2001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Meningitis - pseudomonas DUE TO, OR AS A CONSEQUENCE OF (c) Lymphocytic lymphoma - Stage IV | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7 , 19 76 , to 11/1 , 19 80 , that (1) (we) lost saw the deceased alive on 11/1 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE George Newman II Ph.D., M.D. DEGREE | | | | 22c. DATE SIGNED | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/4/80 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown, Wash., Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md. ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR NOV 7 1980 25b. REGISTRAR'S SIGNATURE Patricia McHugh | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DPHM-16 30M 2/80
(VRA 15, 4)

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 0 2 9 7 9 7 | | REG. NO. | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Gilbert Franklin Romberger | | | | 7a. DATE OF DEATH MONTH DAY YEAR Oct. 3, 1980 | | 2b. HOUR 4:41 P ^M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 20, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 240 Oak Forrest Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Conrail | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gilbert Franklin Romberger | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth C. Romberger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 195 07 8333 | | 17. INFORMANT ADDRESS Loretta J. Romberger see # 13 above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Months</u> <u>Years</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-9-</u> 19 <u>78</u> to <u>6-2-</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>6-2-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Edward W. Ditto</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>Oct 5, 1980</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward W. Ditto, 3rd | | | | 22e. ADDRESS Hagerstown, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-7-80 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE New Cumberland, Penna. | | | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland | | | | 305 N. Potomac St. ADDRESS | | OCT 9 1980 | | REGISTERED [Signature] | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|--|--|---|--|---|--|--------------------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Gary | | MIDDLE Wayne | | LAST SCADDEN | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | MONTH Nov | | DAY 7 | | YEAR 1980 | | 2b. HOUR 2 30 | | PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 10, 1947 | | 6. AGE (IN YEARS) LAST BIRTHDAY 33 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Nov 7 1980 | | 2d. HOUR 3 10 | | PM | | | |
| a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 58 E. Antietam St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | | | 12b. KIND OF BUSINESS OR INDUSTRY Home Improvement | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | | | 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 58 E. Antietam St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Miles O. Scadden | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Rudy | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam War 219-46-2122 | | | | 17. INFORMANT ADDRESS Mr. Miles O. Scadden, Rfd. 1 Box 359 Hagerstown, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fire - Apartment Bldg - E891</u> 8909 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 30 PM NOV 7 1980 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Sunken in - Apartment - gutted by Fire | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Basement Apt | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 58 E. Antietam Hagerstown, Wash. Co. Md | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Dittie III | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED NOV 8, 1980 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dittie III | | | | ADDRESS 212 W. Wark St Hagerstown, Md 2180 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11-11-80 | | | | 23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Beaver Creek, Wash. Co., Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John H. Bast, Jr. | | | | ADDRESS Boonsboro, Md. 21713 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1980 | | | | 25b. REGISTRAR'S SIGNATURE Robert J. Brady | | | | | | | |

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 7 9 9 | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | M | | | |
| Frank Berwyn SHANABROOK | | | | November 21, 1980 | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| male | | white | | Jan. 17, 1910 | | 70 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | U.S.A. | | | | Washington MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | Washington County Hospital | | | | | | maintenance engineer | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | |
| Maryland | | | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Route 8, Box 217 | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Edward Park Shanabrook | | | | Daisy A. Sheaffer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | |
| yes | | | | W.W. 11 | | 195-07-5098 | | Mrs. Margaret Shanabrook, Hagerstown, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| 4415 IMMEDIATE CAUSE (a) <i>Cerebrovascular</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <i>Respiratory failure</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| <i>Respiratory failure of the lungs</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 10-4-80 | | | | Ruptured aortic aneurysm | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. | | 19 | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | |
| DEGREE | | | | | | | | | | | |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| burial | | | | Nov. 25, 1980 | | Rose Hill Cemetery | | Hagerstown, Wash., Maryland | | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740 | | | | | | NOV 28 1980 | | <i>[Signature]</i> | | | |



Handwritten signature or mark

001 B S VOM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 0 2 9 8 0 0 | | | |
|---|--|---|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Lester Elon Shenk | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov 10 1980 | | | 2b. HOUR 9 PM |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH MONTH DAY YEAR Sept 9 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | |
| 10 CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer | | 12b. KIND OF BUSINESS OR INDUSTRY railroad | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 193 W. Wilson Blvd. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Elon D. Shenk | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester C. Jolley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 110-01-4174 | | 17 INFORMANT ADDRESS Mary E. Shenk, Hagerstown, Maryland | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100 | | | | | | | | years |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Cardio. Dis. | | | | | | | | years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4 Nov 68 to date 19 80 , that (I) (we) lost saw the deceased alive on 3 June 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Richard T. Binford DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 6 Nov 80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard T. Binford | | | | 22e. ADDRESS Hagerstown, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 10, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | |
| 24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR NOV 10 1980 | | 25b. REGISTRAR'S SIGNATURE Richard T. Binford | | |
| 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | | |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8029801 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Viola LAST Smith | | | | 2a. DATE OF DEATH MONTH 11 DAY 17 YEAR 80 | | 2b. HOUR 04 PM | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH 5 DAY 17 YEAR 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cavetown Caning | | 12b. KIND OF BUSINESS OR INDUSTRY Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Smithsburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST David MIDDLE H. LAST Baer | | 15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE V. LAST Palmer | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-18-0460 | |
| 17. INFORMANT Mrs. Betty Myers | | ADDRESS Middletown, Md. 21783 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sute myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 14 19 80, to Nov. 17 19 80, that (I) (we) lost saw the deceased alive on Nov. 17 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Gloria F. Para MD - DEGREE | | | | 22c. DATE SIGNED 11/17/80 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PARA | | | | 22e. ADDRESS 382 S. Cleveland Hagerstown | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/20/80 | | 23c. NAME OF CEMETERY OR CREMATORY Marfield Methodist | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wolfsville Frederick Md. | |
| 24. FUNERAL DIRECTOR NAME Bittle Funeral Home ADDRESS Myersville, Md. 21773 | | | | 25. DATE RECD BY REG. 11/21/80 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 0 2 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Mary Grace SPANGLER | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 24, 1980 | | 2b. HOUR M | |
| 3 SEX female | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR August 13, 1902 | | 6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) buyer-clothing | | 12b. KIND OF BUSINESS OR INDUSTRY dept. store | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST David Albert Bloyer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Esther Rubeck | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 173-03-2702 | | 17 INFORMANT ADDRESS Mr. Clyde Spangler, Hagerstown, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis - 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks - | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/8/1941 19 to 11-24 19 80 , that (I) (we) last saw the deceased alive on 11/24 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John H. Hornbaker M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-25-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Hornbaker, M.D. | | | | 22e. ADDRESS 645 E. First St., Hagerstown, MD 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE Nov. 26, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | |
| 24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 28 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP.

5-0-9-1



MALE



1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 0 3 | | | |
|---|--|--|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Lloyd Albertus STINE | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 2, 1980 | | 2b. HOUR 12³⁰ AM | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1922 | | 6 AGE (IN YEARS LAST BIRTHDAY) 57 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 146A East Avenue | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Hubert D. Stine | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Semler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 215-14-1087 | | 17 INFORMANT ADDRESS Mrs. Marjorie G. Stine, Hagerstown, Maryland | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAUSE OF DEATH: CALDO RESPIRATORY ARREST 5715 DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED INTRAVASCULAR COAGULOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) END STAGE CIRRHOSIS, ASCITES WITH LIVER STUNT 1 Year | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION 10/28/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UNRETRACTABLE ASCITES | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from March 11/1 19 80 , to November 19 80 , that (we) last saw the deceased alive on 11/1 19 80 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert J. Trace, Jr. M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/3/80 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Trace, Jr. M.D. | | | | 23b. ADDRESS 138 E. Antietam St. Hagerstown, Md. | | | |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23d. DATE Nov. 4, 1980 | | 23e. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23f. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | |
| 24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR NOV 7 1980 | | 25b. REGISTRAR'S SIGNATURE Barry McBrady | |

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| STATE OF MARYLAND | | | | | | | | | | 70 | | 29804 | |
|---|--|--|--|--|--|--|--|--|--|---|--|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Donald Eugene Swope, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| | | | | | | | | | | ESTIMATED Nov 6 1980 | | 10:30 AM | |
| 3. SEX Male 4. RACE white 5. DATE OF BIRTH Aug. 2, 1980 6. AGE (IN YEARS) 3 7. IF UNDER 1 YR. 4 8. IF UNDER 24 HRS. 4 | | | | | | | | | | 2c. DATE PRONOUNCED DEAD Nov 6 1980 | | 2d. HOUR 10:45 AM | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. 10. CITY OR TOWN OF DEATH Hagerstown | | | | | | | | | | 11. CITIZEN OF WHAT COUNTRY? USA | | 12. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Washington Co. Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Penna. Fulton Needmore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES | | 13e. STREET ADDRESS RD1. | |
| 14. FATHER'S NAME Donald E. Swope | | | | | | | | | | 15. MOTHER'S MAIDEN NAME Julia Decker Swope | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Donald E. Swope, RD1, Needmore, Pa. 17238 | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7980 Sudden Infant Death Syndrome IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF # 798 (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 22b. TITLE (SPECIFY) Deputy | | 22c. MEDICAL EXAMINER Edward W. Dito | |
| 22d. DATE NOV 6, 1980 | | | | | | | | | | 22e. SIGNATURE Edward W. Dito | | 22f. ADDRESS 312 W. Wash. St. Hagerstown, Md 21240 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 9 Nov. 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge Church of Nazarene, Needmore, Fulton, Penna. | |
| 24. FUNERAL DIRECTOR Howard L. Spies | | | | | | | | | | 24a. ADDRESS S.R. 3, Box 7 Harrisonville, Pa. 17228 | | 24b. DATE REC'D. BY REGISTRAR NOV 13 1980 | |
| 24c. REGISTRAR'S SIGNATURE Barney McCready | | | | | | | | | | | | | |

Harrisonville, Mo. 64601
 Box 1
 Nov. 1980
 Harrisonville, Mo. 64601

Donald E. Swope, RDI, Needmore, Va. 22958

Donald E. Swope
 Julia Becker Swope

Tenn. Fulton Needmore
 X RDI

Harrisonville Washington Co. Hospital

Tenn.

Male white Nov. 2, 1980 3 4

Donald Eugene Swope, Jr.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 8 0 5

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stanley Harding TOMS | | | 2a. DATE OF DEATH MONTH DAY YEAR November 21, 1980 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1920 | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator | 12b. KIND OF BUSINESS OR INDUSTRY Mack Truck | |
| 13a. STATE Md. | | 13b. COUNTY Wash. | 13c. CITY OR TOWN Smithsburg | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS Rt. 2, Box 337 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Desamore O. Toms | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertie R. Barkman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II | | 16b. SOCIAL SECURITY NO. 220-10-3442 | 17. INFORMANT ADDRESS Mrs. Ellen V. Toms, Smithsburg, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 5 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 3, 1955, to Nov. 21, 1980, that (I) (X) last saw the deceased alive on Nov. 21, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE Charles F. Hess | | DEGREE M.D. | | 22c. DATE SIGNED 11-24-80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess, M.D. | | 22e. ADDRESS P.O. Box 248, Smithsburg, MD 21783 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 25, 1980 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md. |
| 24. FUNERAL DIRECTOR NAME Davis | | ADDRESS Davis Funeral Home, Smithsburg, Md. 21783 | | 25a. DATE REC'D. BY REGISTRAR NOV 28 1980 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 0 6 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Marion Henry Veazey | | | | 2a. DATE OF DEATH MONTH DAY YEAR November 18, 1980 | | 2b. HOUR 7:00 p.m. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY Industrial | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William M. Veazey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Naudain | | 16. STREET ADDRESS 2050 Greenfield Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- -- -- | | 17. INFORMANT Daisy D. Veazey | | ADDRESS 2050 Greenfield Road Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Coronary Vessel Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute & Chronic Forward Output Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 10 years 3 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Pulmonary Hypertension</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (a) (this hospital) attended the deceased from <u>11/18</u> 19 <u>80</u> to <u>11/18</u> 19 <u>80</u> , that (b) (we) last saw the deceased alive on <u>11/18</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Robert Brull</u> | | | | DEGREE M.D. | | 22c. DATE SIGNED 11/20/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull M.D. | | | | 22e. ADDRESS 1198 Kenly Avenue, Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-21-80 | | 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium | | 23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington, Md. | |
| 24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md. | | | | 25. DATE REC'D. BY REGISTRAR NOV 25 1980 | | 26. SIGNATURE <u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 2 9 8 0 7 | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ALICE | | MIDDLE MARIE | | LAST WARD | | 2a. DATE OF DEATH MONTH DAY YEAR November 27, 1980 | | 2b. HOUR 6:54 PM | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 10, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife/Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Keedysville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1 Box 179-B | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John F. Tenney | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Alice Howes | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 235 62 1783 | | 17. INFORMANT Arthur Ward | | ADDRESS P.O. Box 266 Brunswick, Md. 21716 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Murder myocardial infarction</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic sclerosis</u> (c) <u>Diabetes Mellitus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>Dec 9</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 9</u> , 19 <u>77</u> , to <u>Nov 27</u> , 19 <u>80</u> , that (I) (we) lost <u>the deceased alive on Oct 16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, we did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE <u>Galen F. Brooks</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Galen F. Brooks, M.D. | | | | 22e. ADDRESS 4 West 7th Street, Suite 3 Frederick, MD 21701 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 30, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Monrovia, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME John T. Williams Funeral Home Brunswick, Md. 21716 | | | | | | | | | | | |

MEDICAL CERTIFICATION

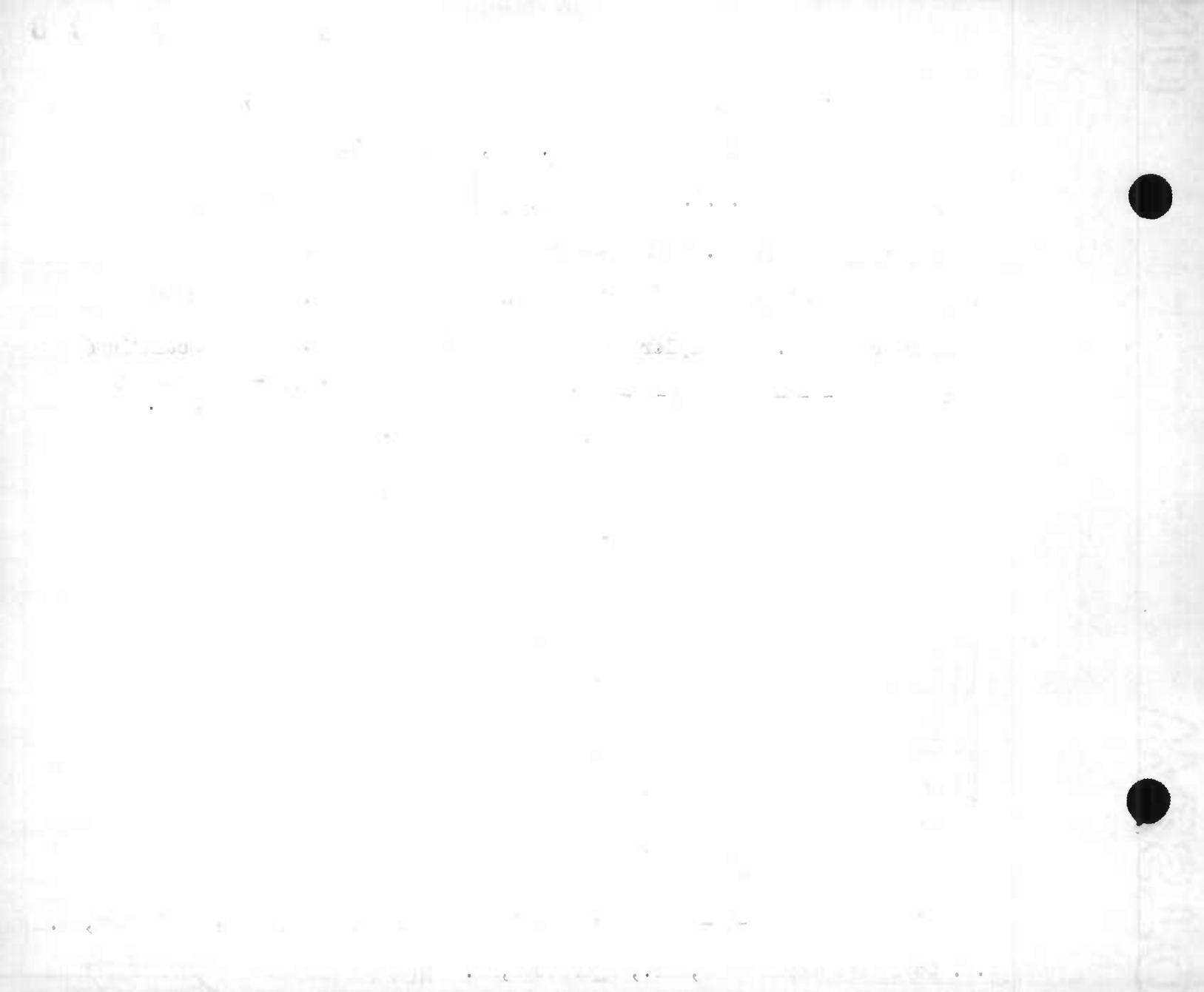
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 0 8 | |
|---|---|---|--|--|-----------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Mildred Ruth Wasson | | | 2a. DATE OF DEATH November 7, 1980 | | 2b. HOUR 8 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Oct. 24, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD. | | |
| 10. CITY OR TOWN OF DEATH Maugansville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 318 N. North Street | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Maugansville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 318 N. North Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence H. Eyer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara V. McClelland | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-26-8309 | 17. INFORMANT ADDRESS Clara May Frey Box 359-A Route # 3 Williamport, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Other sclerotic cardiovascular disease 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/78, 19 to 11/7 1980, that (I) (we) last saw the deceased alive on 10/15 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Frederic H. Kass III | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/8/80 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass III | | | 22e. ADDRESS 1825 Howell Rd, Hagerstown Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-10-80 | | 23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery | |
| 24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md. | | ADDRESS A.K. Coffman Funeral Home, Inc., Hagerstown, Md. | | 25a. DATE REC'D. BY REGISTRAR NOV 13 1980 | |
| | | | | 25b. REGISTRAR'S SIGNATURE History McCreedy | |

BP



BP

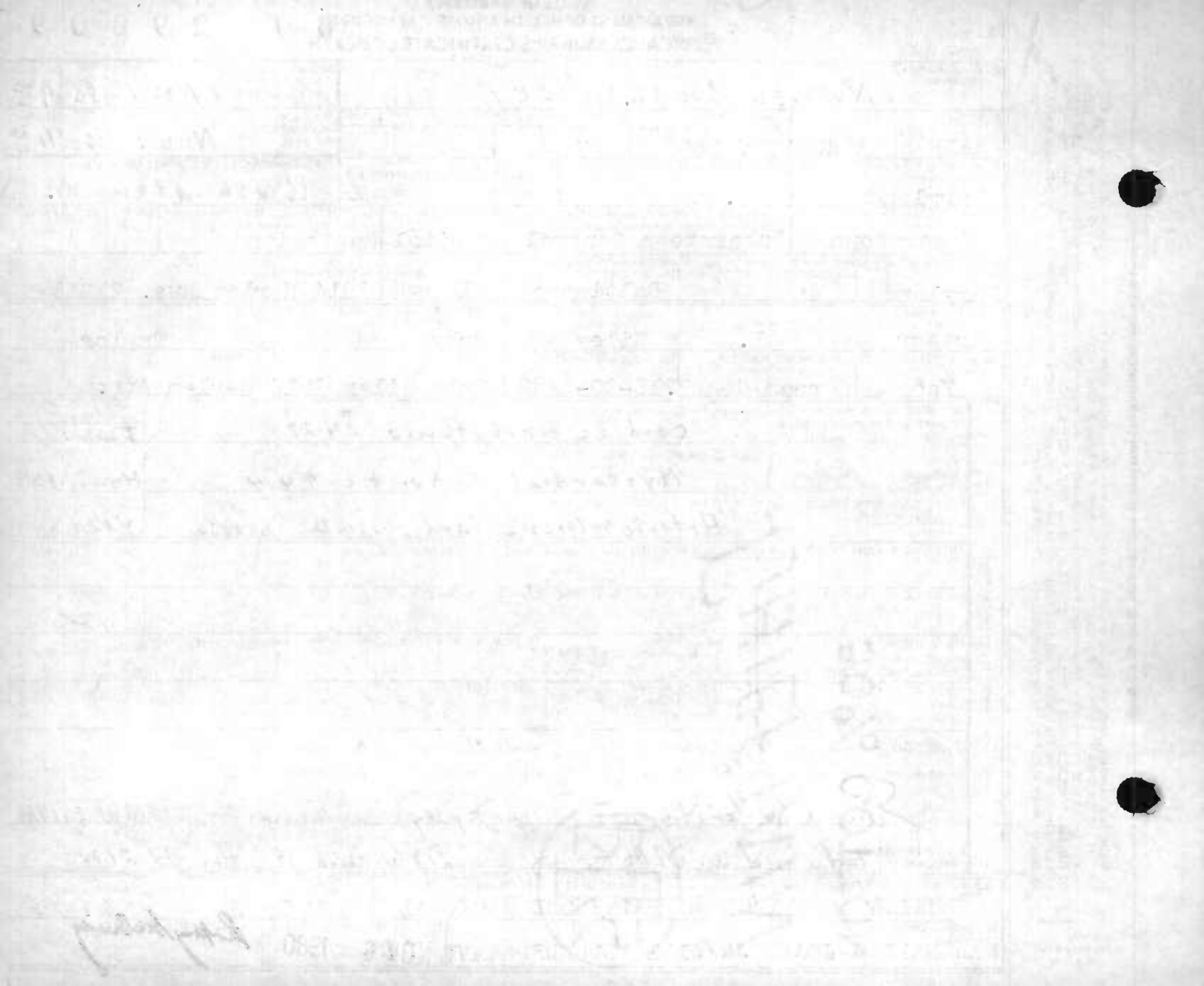
DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-------------------------|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NORMAN LEE (L.) WILEY | | | 20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Nov 1 1980 | | | 21. DATE PRONOUNCED DEAD Nov 1 1980 | | |
| 2. SEX MALE | 3. RACE NEGRO | 4. DATE OF BIRTH MONTH DAY YEAR SEPT 24 1933 | 5. AGE (IN YEARS) (LAST BIRTHDAY) 47 YRS. | 6. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. BALTIMORE CITY OR COUNTY OF DEATH Washington CO. MD. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian | | |
| 12. CITY OR TOWN OF DEATH Hagerstown | | | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hagerstown General Hospital | | | 14. KIND OF BUSINESS OR INDUSTRY | | |
| 15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Maryland | | | 15b. COUNTY Baltimore | | | 15c. CITY OR TOWN Baltimore | | |
| 16. FATHER'S NAME FIRST MIDDLE LAST Arthur L. Wiley | | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Taylor | | | 18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 20. SOCIAL SECURITY NO. 1216-30-1282 | | | 21. INFORMANT Ruby Wiley/3014 Harlem Avenue | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Dittman | | | TITLE (SPECIFY) M.D. Deputy | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dittman MD | | | ADDRESS 212 W. Walsh St - Hgt. Md 21240 | | | DATE SIGNED Nov 2, 1980 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 11/05/80 | | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | |
| 24. FUNERAL DIRECTOR NAME MARSHALL W JONES JR | | | ADDRESS 4101 EDMONDSON AVE | | | 25a. DATE REC'D. BY REGISTRAR NOV 6 1980 | | |
| 25b. CITY OR TOWN BALTIMORE | | | 25c. COUNTY MARYLAND | | | 25d. STATE MARYLAND | | |



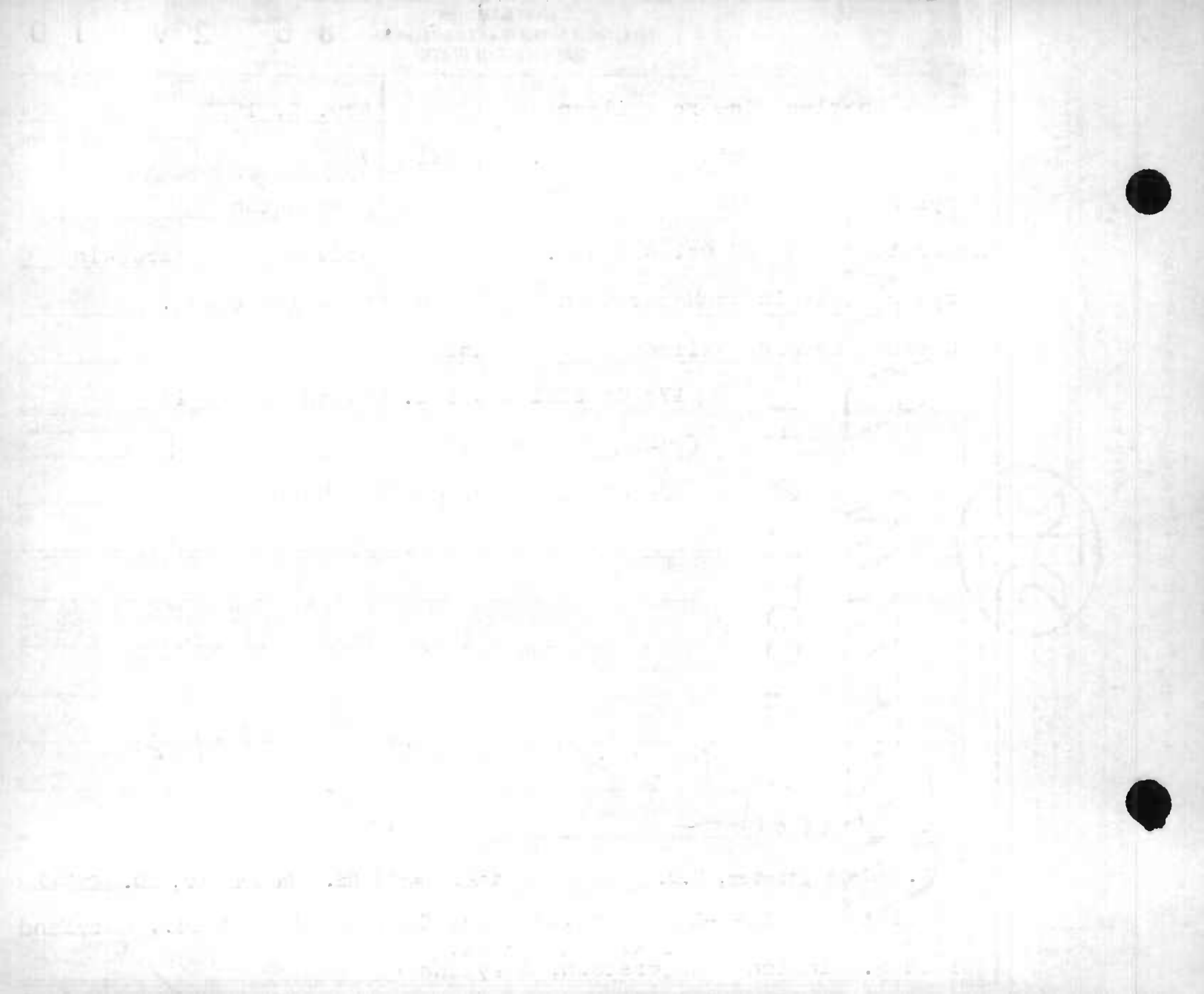
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 1 0 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Charles Edward Wilson | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 5, 1980 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 60 Delwood Ave. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) driver | | 12b. KIND OF BUSINESS OR INDUSTRY trucking | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Edward Wilson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 176 05 260 | | 17. INFORMANT ADDRESS David E. Wilson see # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESP. ARREST</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY ART. DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>75</u> to <u>11/2/80</u> , that (I) (we) lost spw the deceased alive on <u>11/2/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>L. Dwight Wooster</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Dwight Wooster, M.D. | | | | 22e. ADDRESS 1825 Howell Rd. Hagerstown, MD. 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-8-80 | | 23c. NAME OF CEMETERY OR CREMATORY Samples Manor Cem. Washington Co., Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Gerald N. Minnich | | 305 N. Potomac St. Hagerstown, Maryland | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1980 | | 25b. REGISTRAR'S SIGNATURE <u>Kathy McRuddy</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

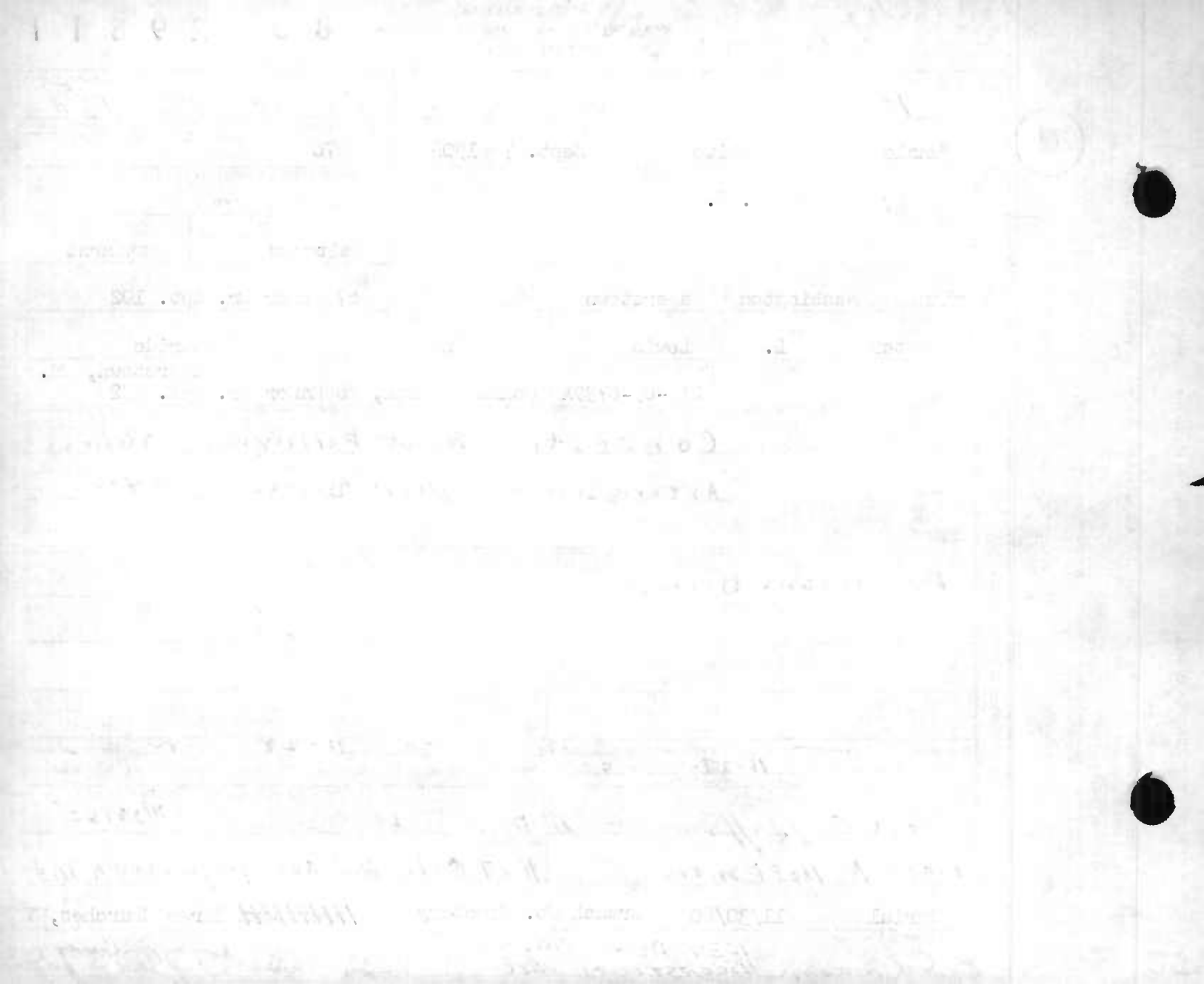
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 1 1 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Hazel L. Wilson | | | | 2a. DATE OF DEATH MONTH DAY YEAR Nov. 28, 1980 | | 2b. HOUR 1:15 A M | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 7 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY Restuarnt | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 67 Manor Dr. Apt. 102 | |
| 13a. STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. STREET ADDRESS 67 Manor Dr. Apt. 102 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Peter L. Lewis | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iona McBride | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-05-6739A | | 17 INFORMANT ADDRESS Joann Wilson, 76 Manor Dr. Apt. 102 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 7 yrs | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinsons Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12 19 70 to 11-28 19 80 , that (I) (we) last saw the deceased alive on 11-27- 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Lloyd A. Hoffman | | | | DEGREE M.D. | | 22c. DATE SIGNED 11/28/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lloyd A. Hoffman | | | | 22e. ADDRESS 1147 Oak Hill Ave. Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/30/80 | | 23c. NAME OF CEMETERY OR CREMATORY Branch Mt. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Three Churches, WV | |
| 24 FUNERAL DIRECTOR NAME 1037 Deval Place Ed. S. Dawson Hagerstown Md. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 3 1980 | | 25b. REGISTRAR'S SIGNATURE John J. McHenry | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 0 2 9 8 1 2 | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Lee Ward WILSON | | | | | | 2a DATE OF DEATH MONTH DAY YEAR November 23, 1980 | | | | 2b HOUR M | | | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 24, 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Hagerstown | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Mach. Mate | | 12b KIND OF BUSINESS OR INDUSTRY U.S. Navy | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Washington 13c CITY OR TOWN Hagerstown | | | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 227 Bryan Place | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST David H. Wilson | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verna Ward | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) W.W.II | | 17 INFORMANT ADDRESS Mrs. Marie L. Wilson, Hagerstown, Md. | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>recurrent gastric carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>with metastases</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 months</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Nov 22</u> 19 <u>80</u> to <u>Nov 23</u> 19 <u>80</u> that (I) (we) last saw the deceased alive on <u>Nov 22</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE <u>[Signature]</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <u>11/24/80</u> | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. SU</u> | | 22e ADDRESS <u>239 North Potomac St. Hagerstown, Md</u> | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b DATE Nov. 26, 1980 | | 23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park | | 23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | | | | | |
| 24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | 25a DATE REC'D. BY REGISTRAR NOV 28 1980 | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 80 | 29813 | |
|--|--|---|---|--|-----------------------------------|--|---|---|--|---|-------|----------|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 7b. HOUR |
| Harry Sylvester WILT | | | | | | November 3, 1980 | | | | | | 2:15 A M |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| male | | white | | May 23, 1913 | | 67 | | MONTHS | | DAYS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Pennsylvania | | USA | | | | Washington | | | | MD. | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Hagerstown | | Washington County Hospital | | | | installer | | Modern Metals | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13b INSIDE CITY LIMITS? | | 13c STREET ADDRESS | | | | |
| 13a STATE Maryland | | | | | | 13b CITY OR TOWN Washington | | 13c HAGERSTOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME | | | | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST John Wilt | | | | | | FIRST MIDDLE LAST Mary Reese | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | | |
| No | | | | 212-14-7275A | | Dorothy L. Wilt, Hagerstown, Maryland | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) Liver failure | | | | | | | | | | 2 days | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) Hemorrhage from esophageal varices and gastric ulcer | | | | | | | | | | 14 days | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| Chronic obstructive pulmonary disease and Osler Weber-Randue Disease | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a I certify that (this hospital) attended the deceased from Oct. 19, 1980, to Nov. 3, 1980, that we saw the deceased alive on Nov. 3, 1980 and that in our opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death. | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | 22c DATE SIGNED | | | | |
| W. T. Layman, M.D. | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 11/4/80 | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e ADDRESS | | | | | | |
| W. T. Layman, M.D. | | | | | | 301 E. Antietam St., Hagerstown, MD. | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | | |
| burial | | | Nov. 6, 1980 | | Cedar Lawn Mem. Park | | | Hagerstown, Wash., Maryland | | | | |
| 24 FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | |
| | | | | | | NOV 7 1980 | | [Signature] | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 8 1 4

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|---------------------------------------|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ISABEL Jane WISE | | | 2a. DATE OF DEATH MONTH DAY YEAR 11 22 80 | | | 2b. HOUR 0840 <small>M</small> | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 00 00 | | 7b. IF UNDER 24 HRS HOURS MIN. 00 00 | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Beaver Creek, Md. | | 8b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington <small>MD.</small> | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Boonsboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Rfd. 2 Box 340 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edgar R. Shoop | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth E. Moser | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO 220-52-1602 | | 17. INFORMANT ADDRESS Mr. Paul T. Wise, Rfd. 2 Box 340, Maryland | | | | | |

| | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/22/80 19 80 , to 11/22 19 80 , that (I) (we) lost saw the deceased alive on 11/22/80 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David T. Harper MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 11/22/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID T. HARPER MD | | | | | | 22e. ADDRESS WASH. CTY - HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 11-25-80 | | 23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Beaver Creek, Wash. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME John H. Bast, Jr. | | | | | | ADDRESS Boonsboro, Md. 21713 | | 25. DATE REC'D. BY REGISTRAR NOV 28 1980 | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 29815

REG. NO.

| | | | | | | | | | | | | | |
|--|---|--|---|--|---|---|--|---|--------------------------------------|---|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 1 DECEASED NAME (TYPE OR PRINT) | | FIRST Leon | MIDDLE Noble | LAST WYAND | 2a. DATE OF DEATH | MONTH November | DAY 20, | YEAR 1980 | 2b. HOUR 10:30P _M | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH May 30, 1911 | YEAR 1911 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | | | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Keedysville, Md. | 11. CITIZEN OF WHAT COUNTRY? U. S. A. | 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 13. BALTIMORE CITY OR COUNTY OF DEATH Washington MD. | | | | | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | 12b. KIND OF BUSINESS OR INDUSTRY Furniture Mfg. | | | | | 13a. STATE Maryland | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Boonsboro | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 314 N. Main St. | | | | | 14. FATHER'S NAME FIRST George | | | | |
| 14. FATHER'S NAME FIRST George | MIDDLE M. | LAST Wyand | 15. MOTHER'S MAIDEN NAME FIRST Sarah | | | | | MIDDLE Goldie | LAST Leatherman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-2461 | 17. INFORMANT ADDRESS Mrs. Cora C. Wyand, 314 N. Main St. Boonsboro, Md. 21713 | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 5, 19 67, to Nov. 20, 19 80, that (I) (we) lost saw the deceased alive on Nov. 20, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE R. Amarillo | | DEGREE M-D | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11/20/80 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO | | 22e. ADDRESS 127 KING ST HAGERSTOWN MD 21740 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | 23b. DATE 11-23-80 | | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME John H. Bast, Jr. | | | | ADDRESS Boonsboro, Md. 21713 | | | | 25a. DATE RECD. BY REGISTRAR NOV 24 1980 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1. STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 0 2 9 8 1 6 REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Richard D. Lane</i> | | | | 2a. DATE OF DEATH <i>11-18-80</i> | | | | 2b. HOUR <i>10:55 AM</i> | | | |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH MONTH DAY YEAR <i>March 19 1901</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>WASHINGTON</i> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH <i>Hagerstown</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Foreman</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>State Road</i> | | | |
| 13a STATE <i>Maryland</i> | | | | 13b CITY OR TOWN <i>Washington</i> | | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d STREET ADDRESS <i>Rt. #1 Box 86A</i> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Younker</i> | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jane Shoemaker</i> | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>219 36 3576</i> | | 17 INFORMANT <i>Elsworth E. Younker</i> | | | | ADDRESS <i>.867 Mulberry Ave. Hagerstown, Md.</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, or 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Large Heart Failure</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>On 11-18-80, 11:00 AM, 11:00 AM, 11:00 AM</i> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4:10 P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE <i>410 19 80 to 11-12-80</i> | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>11-18-80</i> 19 <i>80</i> , to <i>11-12-80</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE <i>R. D. Lane</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED <i>11-18-80</i> | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. D. Lane</i> | | | | 22e ADDRESS <i>382 N. W. Street, Hagerstown, Md.</i> | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b DATE <i>11-21-80</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>St. Peters Catholic</i> | | | | 23d LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown Washington MD.</i> | | | |
| 24 FUNERAL DIRECTOR NAME <i>Richard D. Lane</i> | | | | ADDRESS <i>Hagerstown MD.</i> | | | | 25a DATE REG'D. BY REGISTRAR <i>NOV 21 1980</i> | | | |
| | | | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |



1981-1982

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 9 8 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Caroline Elizabeth ZOMBRO | | | 2a. DATE OF DEATH MONTH DAY YEAR November 6, 1980 | | | 2b. HOUR MIN 2:15 P. | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 14, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 50 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE CITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Fred. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 914 Chestnut St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GRAHAM MOWERY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED SNYDER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 232-32-7316 | | 17. INFORMANT ADDRESS James Zombro Frederick, Md. 21701 | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse cerebrovascular spasm 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured aneurysm, right internal carotid DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 weeks | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | | | | |
| 19a. DATE OF OPERATION 10-31-80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracranial aneurysm | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-19-80 , 19____, to____, 19____, that (I) (we) lost saw the deceased alive on____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. Abdullah, M. D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11-7-80 | | |
| 22e. ADDRESS 318 N. Potomac St. Hagerstown, Md. 21740 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Nov. 10, 1980 | | 23c. NAME OF CEMETERY OR CREMATORY Rosedale Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkley W.Va | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Gladhill Co. Middletown, Md. 21769 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 13 1980 | | 25b. REGISTRAR'S SIGNATURE | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

November 6, 1930

Nov. 11, 1930

Continued

Page 10

U.S.A.

Pa.

Honorable G. W. Jones

Honorable G. W. Jones

214 Chestnut St.

Phila., Pa.

Id.

RECEIVED

NOV 11 1930

NOV 11 1930

NOV 11 1930

232-32-7316 James Joseph Hendricks, Jr.

No.



United

Nov. 10, 1930

NOV 11 1930

Nov. 10, 1930